AIDS EDUCATION for STUDENT YOUTH

A Training Manual

3rd Edition
(Revised)

UNIVERSITIES talk AIDS

National Service Scheme
Department of Youth Affairs & Sports
Ministry of Human Resource Development
Government of India. New Delhi

राष्ट्रीय सेवा योजना
NATIONAL SERVICE SCHEME

AIDS EDUCATION for STUDENT YOUTH

A Training Manual

Edited by : ***Dr. Bhagbanprakash***

Universities Talk AIDS
National Service Scheme (NSS)
Department of Youth Affairs & Sports
Ministry of Human Resource Development
Government of India
New Delhi-110001

First Edition : 1993
2nd Edition (Revised) : 1994
3rd Edition (Revised) : 1994

For more information contact:
Programme Advisor's Cell
National Service Scheme
12/11, Jamnagar House
New Delhi-110011
Ph: 384513

THE CORE RESOURCE TEAM

1. Dr. Bhagbanprakash, Programme Adviser, NSS I/C & Director, UTA, Deptt. of Youth Affairs & Sports, Govt. of India, Delhi.

2. Ms. Gurmeet Hans, Senior Programme Officer, Commonwealth Youth Programme, Asia Centre, Chandigarh.

3. Dr. Purnima Mane, Reader, Department of Medical & Psychiatric Social Work, T.I.S.S.,Bombay.

4. Ms. Carol Larivee, Health Education Specialist, Global Programme on AIDS, WHO, (India).

5. Ms. Jasmeet Kaur, Consultant, Sex Education and Counselling, Bombay.

6. Prof. Kalindi Muzumdar, Former Vice-Principal, Nirmala Niketan, School of Social Work, Bombay.

7. Mr. Mahesh Mahalingam, National Consultant, Youth Programming, National AIDS Control Organisation (NACO), Delhi.

8. Dr. L.N. Balaji, Chief, Research, Monitoring, Planning Section, UNICEF, India Country Office, Delhi.

भारत सरकार
मानव संसाधन विकास मंत्रालय
युवा कार्यक्रम और खेल विभाग
नई दिल्ली - 110 001

GOVERNMENT OF INDIA
MINISTRY OF HUMAN RESOURCE DEVELOPMENT
DEPARTMENT OF YOUTH AFFAIRS & SPORTS
NEW DELHI - 110 001

सचिव
SECRETARY

Foreword

The 'Universities Talk AIDS' (UTA) programme launched with technical assistance from WHO continues to be the largest national effort in sensitising the student youth on HIV/AIDS, its causes, consequences and prevention. However, the UTA-Youth Awareness Campaign, since its beginning, was handicapped for want of a suitable training guide. The present Trainer's Training Manual with its **emphasis on peer education** is the fulfillment of a long felt need for creating a critical mass of trainers and educators who could confront the challenges of HIV/AIDS pandemic with courage and confidence. The young people throughout the world continue to be one of the most vulnerable groups to the AIDS pandemic and hence it is essential to equip them with adequate knowledge and skills which have a positive bearing on their behaviour and practices.

It is our sincere hope that the Training Manual now revised and redesigned by the UTA National Cell, would prove to be an effective resource for all those youth groups, peer educators and trainers who are out to fight the evil with information, education and communication. To that extent, the Manual tries to address the issues in innovative and sensitive ways through a variety of participatory games, interactions and exercises designed and developed by a team of experienced resource persons. Although the Manual aims at the student youth in higher education system as its clientele, it **can also be used with marginal variation, for and by all the youth in general.**

I would like to take this opportunity to record our appreciation for the technical assistance provided by the WHO and NACO and the initiative taken by the NSS, UTA National Cell in Delhi and the TORC, Tata Institute of Social Science, Bombay in bringing out this very useful training and resource pack.

(B.N. Bhagwat)
Secretary
Deptt. of Youth Affairs & Sports
Govt. of India
New Delhi.

To All Those Who Made It Possible...

The arrival of HIV/AIDS has shaken humanity and human relationships to its roots. The youth in particular have been greatly affected by it. Thus educating youth for AIDS prevention is a major challenge to teachers and trainers. The Universities Talk AIDS (UTA) Project is one such effort. Initiated by the National Service Scheme in the Department of Youth Affairs and Sports, Government of India, it aims to impart AIDS education to the student community at the higher secondary and university levels of study. *AIDS Education for Students : A Training Manual* is a supporting document for this project. It could, however, also be of use to others working in the field of AIDS prevention. The department has prepared a national plan of action to cover all categories of the youth under a massive awareness campaign on HIV/AIDS. Covering such a large youth population of around 300 million on a sensitive and critical issue like AIDS requires herculean efforts which could be overcome by collective participation of youth. A well thought of training and education programme is relevant in this context.

The manual adopting **a 'Youth to Youth' approach,** has been prepared to standardise the training component in the UTA and also to equip NSS personnel to undertake training of students more effectively. In India, the relevance of this effort should be seen in the context of the dearth of trainers in general and lack of AIDS expertise in particular, especially in small towns and villages.

Besides our efforts and contribution of the UTA cell this manual is **an outcome of teamwork** involving many people. We are very thankful to *Dr. A.S. Desai,* Director, Tata Institute of Social Sciences for her cooperation in sparing two of her faculty, namely Mrs. Gurmeet Hans and Mrs. Purnima Mane who worked very hard in the preparation of first edition of this training manual. The expertise and cooperation of co-contributors, *Ms. Carol Larivee, Mr. Mahesh Mahalingam, Prof. Kalindi Muzumdar and Ms. Jasmeet Kaur* have been crucial to the completion of this task. We were fortunate to receive constructive feedback on the manuscript from a variety of experts who included *Dr. M. Watsa,* Consultant, Family Planning Association of India, Bombay, *Dr. Johannes vanDam,* Medical Officer (STD) GPA-I/WHO, *Dr. S Sundararaman,* AIDS Research Foundation of India, Madras, *Mrs. Rekha Dutta,* Coordinator, TORC, Delhi, *Dr. L. N. Balaji and Dr. Prakash Gurnani,* UNICEF, *Dr. T. Manoj Kumar,* CMC, Vellore *Ms. Gulan Kriplani,* Lintas, *Ms. V. Chitale,* TISS, *Dr. R.R. Ganga Khedkar,* Institute of Immunahaematology and *Dr. Asha Bhende,* Consultant. We also acknowledge the contribution of New Opportunities for Women (NOW), New Delhi for designing the visuals. This manual has been revised and reedited on the basis of feedback and comments received from various quarters.

Dr. Bhagbanprakash, Director, UTA and his colleagues, Mr. S.K. Sawhney and Mr. Rajkumar Bidla along with Mr. B. Yalmanda, Mr. Ved Prakash and Mr. Sayeeram in the UTA cell have worked almost round the clock in editing and preparing the revised manuscript for the 2nd edition. They deserve all credit for this.

NSS is a **value-oriented voluntary organisation** of the student youth known for its constructive response to social challenges from time to time. The training manual has been designed to help the student youth in campus and community in their resolve to fight AIDS. We look forward to its use in the field and will be most happy to receive any constructive suggestions and feedback from the users of this manual.

Dr. S. Y. Quraishi
Joint Secretary, (Youth Affairs)
National Coordinator, Youth Programmes on AIDS
Deptt. of Youth Affairs & Sports
Govt. of India

May 1994, Delhi

Introduction

The incidence of behaviours that place youth at risk for drug abuse, sexually transmitted diseases, unwanted pregnancies and now HIV/AIDS, is steadily increasing in school, college and university environment. In the present context, education for preventive behaviour and health care seems to be the only answer to such problems. As,among all the infections, HIV/AIDS is the most fatal, an awareness generation project called "Universities Talk AIDS" (UTA) was conceived and launched in India in 1991 to provide AIDS Education to students, and to promote positive attitudes and healthy lifestyles among them. It is being implemented through the National Service Scheme (NSS) a voluntary, value-based and community-service-oriented student-youth organisation now operating in all Indian Universities with 1.1 million volunteers in its fold. In the current phase of the project, the NSS Units will strive for AIDS Education for the entire student-community of their respective colleges/schools, with student peer leaders as communicators. The youth are always prone to peer influence and peer pressure. **All over the world, an average teen opens up and listens to another teen as the most reliable source of information on sexuality.** Because of this, peer education proves to be the most effective way of changing attitudes and practices related to risk-taking behaviour among the youth. It is always **easier for youth to reach other youth, as they use their own idiom, know their likes and dislikes, compulsions and motivations.** Most importantly, it is they, who know what it's like to be a young person. The ultimate objective of the training manual is to empower these young peer groups through training the teacher-trainers and adult educators.

TRAINING

The success of the UTA Project, now being implemented through the NSS network, will depend on the quality and adequacy of training inputs to those who are to coordinate the project and/or provide leadership to it at the field level. The categories of functionaries to be trained are, personnel working at the Regional Centres, State Liaison Cells (NSS), the NSS Programme Coordinators at the University level and the NSS Programme Officers and student peer leaders at the college and +2 school level, besides the faculty of the NSS training centres (TOC/TORCs) in the country. In addition, the teachers/functionaries in charge of student welfare can also be covered by the manual.

The overall objective of training here is to equip the trainees to undertake the AIDS Education for

the Student Youth effectively so as to achieve the learning outcome expected at the student level. The **specific objectives** of the training are:

1. To impart information on medical and psycho-social aspects of HIV/AIDS and its prevention.

2. To provide correct information on human sexuality and to equip the trainees with appropriate skills in communicating on such matters.

3. To impart knowledge and skills in awareness and motivation oriented communication for AIDS Education.

4. To equip the trainees and peer educators to prepare and execute a plan of action for Institution and campus based activities on HIV/AIDS.

As the training for NSS field functionaries and other educators and trainers is likely to be decentralized to a greater extent, this manual especially pertains to training of field workers, i.e. NSS Programme Officers, other teachers and student peer leaders. However, as earlier stated, the other youth functionaries can also be trained broadly along similar lines.

It is recommended that a four days training be conducted for NSS Programme Officers and three days for student leaders and peer educators. The training should seek changes not only at the cognitive level, but also at the attitudinal/behaviour and practice levels. It is, therefore, strongly recommended that the **training strategy be participatory in nature,** using methods like interaction, discussion, role-play, brainstorming, simulation exercises and other group activities. The trainers must seek the **full engagement of the trainees with the learning process.** This will be possible, if the size of the trainee group does not exceed 40.

RATIONALE

This manual is designed as a **resource guide** to help in the training of NSS and other youth programme functionaries. Since training for UTA is likely to be organised by more than one agency, it is important that the training input for the project be standardised. This is essential to ensure that expected project outcome is achieved.

Besides standardising the training component, this manual also aims at helping the trainees to plan and provide for the training teams at the institutional level. Once the training team is properly trained and positioned, the basic messages and content including skills are to be passed on to peer educators in a more compact and synthesised form. In this way only, the four day trainers' training could be transformed into three day peer education programme with some imagination.

Further, it is often seen that some gaps and losses in training occur on account of the differential pace of learning by individual trainees. There may be gaps caused by a time lapse between training and its actual application. The manual will help bridge such gaps and provide for losses, if any, as the trainers can always come back to it for guidance.

To serve these purposes, the six modules i.e. (i) HIV/AIDS:Issues and facts(ii) Human Sexuality (iii) Psycho-social impact (iv) Prevention (v) Communication Skills and (vi) Action Plan Development in the manual are presented in detail to facilitate its use by NSS personnel and students responsible for project planning and implementation. Although there is no scope for subjective interpretation of content, the trainers, wherever they feel it appropriate, can readjust the training schedule to save time or to suit convenience or even to introduce innovations to make it more user-friendly. In this context, I would like to urge upon all the users of the manual to sincerely go through Chapter I on Training Modules and understand the guidelines and tips in order to tackle this sensitive subject more effectively. The manual, now revised on the basis of constructive feedback from various sources is a maiden attempt to provide at one source the content and training strategies for HIV/AIDS/STDs prevention in the Indian context and we shall appreciate further suggestions from the users to improve it in future.

(Dr. Bhagbanprakash)
Programme Advisor I/C &
Director (UTA)
Department Of Youth Affairs & Sports,
Government of India.

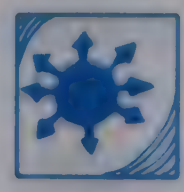
CONTENTS

CHAPTER 1

TRAINING MODULES

On the basis of the training objectives, the manual has been divided into six modules. These are:

Module 1 : HIV/AIDS - Issues and Facts

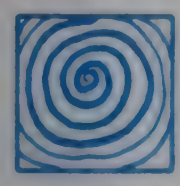


This module is aimed at eliciting the current levels of knowledge of the participants and based on that through a question and answer session, improve their knowledge of HIV/AIDS. It also helps participants to have an understanding of basic concepts and facts related to HIV/AIDS, various risk situations that could lead to sexually transmitted diseases and HIV infection. There is an emphasis on creating a personal awareness and concern for the problem. These objectives are achieved through two sessions; the first by questions and answers and the second through a presentation followed by discussion.

Module 2 : Human Sexuality

Through this module young people would be able to understand the psycho-social aspects of HIV and AIDS as well as the need for adopting safe and preventive behaviour through a proper understanding of human sexuality. Thus it seeks to provide a conceptual clarity on sexuality, myths and facts, the process of growing up amongst boys and girls and adopting safe and healthy life styles. Basic information on sexually transmitted diseases and their prevention is also given in this module. In addition to enabling the participants understand various aspects of sexuality, the module attempts to develop a conviction towards responsible sexual behaviour and positive and healthy life style. This module also develops the competence of participants to discuss the subject factually without embarrassment in small and large groups in a training atmosphere.

Module 3 : Psycho-Social Impact of HIV/AIDS



Any discussion or training on HIV/AIDS invokes amongst the participants a major discussion on personal feelings and attitudes towards HIV/AIDS related issues. In this module an attempt is made to sensitize the participants to the complex psycho-social ramifications of HIV/AIDS and appreciate the impact of HIV/AIDS not only on the individual who is directly affected by the virus but also on various aspects of life, immediate family members, individuals in work place and others in the society. This has been attempted through certain games that primarily help the trainees to enunciate their views on different types of behaviour related to HIV/AIDS and on persons with HIV/

AIDS. An opportunity is given for these views to evolve by encouraging a discussion and sharing amongst participants in groups. There is also an activity (which is optional) to enable participants recognize prejudices towards certain groups that any one of them may have as members of a society.

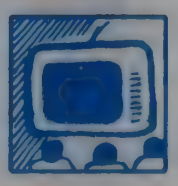
Participants are also given an opportunity to hypothesize on the impact of HIV/AIDS on human life, especially their own. This is essentially done to personalize the experience and to give them an opportunity to review their personal attitudes and feelings about HIV/AIDS. One of the sessions also focusses on developing sensitivity amongst the participants on the supports and services that are needed from the society by persons with AIDS and their immediate family members.

The activities and exercises that can be used to sentisize participants to the above aspects are presented in detail in this module along with certain instructions on how these activities may be conducted and the major learning points that would require to be emphasized during the discussion that follow.

Module 4 : Prevention of HIV/AIDS and Preventive Behaviour.

This section focusses primarily on providing information on the important role of behaviour in the transmission of STDs, HIV and AIDS. After a brief introduction to the risk behaviours under different categories i.e. sexual transmission, transmission through blood and blood products, transmission from a mother to a child, there is an activity to analyze who is taking more risk. This activity is to be conducted in small groups and is followed by detailed discussion. The module then focusses on attainment of life-skills in the area of assessment of risks, making choices, handling peer pressure, saying no to risk behaviours such as unprotected sex, use of drug or alcohol and practices which are not healthy. There is also a session on being comfortable regarding talking about and touching a condom, as well as on learning about the correct method of using a condom. Considerable emphasis is placed in this module to develop skills in the area of saying no, handling peer pressure using condoms or making choices which are safe or safer.

Module 5 : Communication Skills



This module seeks to enhance the participant's personal communication abilities and helps them to convey accurate information on HIV/AIDS prevention and behaviour change. This is done by helping trainees understand the essential components of effective communication, acquire various skills necessary to impart information on HIV/AIDS and sexuality as well as to increase self awareness of their personal strengths and weaknesses while communicating with individuals on a person to person basis or in groups. Series of exercises and activities which are done in a participatory manner address this issue.

Module 6 : Action Plan Development

The participants are, on completion of the training, expected to carry out two types of activities. First is to carry out further training at college/school level for teachers and peer educators. The second set of activities relate to using various modes of spreading awareness about HIV/AIDS and enable participants to get interested in the subject and thereby learn more about the problem. In this section, participants learn through a process of brainstorming and actual preparation of a Plan of Action at college/school level.

Activities at college/school level include creation of an environment appropriate to learning, imparting core information and education related to HIV/AIDS, reinforcement with supplementary and additional input and finally evaluation of the activities carried out. Some aspects of preparing a project plan of action and reports are also included in this module.

Guide to use the Training Manual

The modules in the training are linked to each other and seek to supplement one another to give the participants a comprehensive understanding of the HIV/AIDS issue in our socio-cultural set up, bring about related attitudinal changes, promote healthy life styles and preventive behaviours and provide necessary skills such as communication abilities and preparation of a project plan of action and its implementation. It is, therefore, absolutely essential that the entire training manual is completed unless otherwise stated in case of certain activities as being optional.

While carrying out activities described in this manual, it is possible that some of the names in the manual are the names of either facilitators and trainers or of participants. In such an event, the names should be changed before beginning the activity. In certain regions of the country it is possible that some aspects of the problem require additional information or emphasis. For eg. in those areas where drug addiction and sharing of needles is a major problem, greater emphasis on spread of infection through widespread sharing of needles is required. The training content may also require to be adapted to make it culture-specific in certain cases.

Guidelines to Training

1. Emphasis on Empowerment of The Participant

Throughout the training there must be an emphasis on posing questions and seeking solutions to these by the participants, by application of their critical thinking and creativity. This will empower the participants to apply the knowledge gained to various situations, some of which may not

necessarily be dealt with during the training itself. It would also make them more committed and convinced of the need for changes especially when they arrive at them through their own reasoning and understanding.

2. Participation of Trainees

The facilitators and the trainers must strive to create an appropriate climate for adequate participation of the trainees. Special care needs to be taken in groups to ensure that all members are encouraged to participate. A trainer will have to be **observant, and encourage silent members to open up**. In a mixed group if either of the sex is in minority, the trainer or facilitator will have to put in special efforts to draw their active participation. Further, the trainers should ensure that all discussions during training **are kept confidential** by all members of the group.

3. Choice of Facilitators/Trainers

For conducting a training programme of NSS programme officers and peer leaders drawn from colleges, the trainer could be an NSS organiser specially trained under the programme, an expert on HIV/AIDS with adequate knowledge of medical and psycho-social aspects of STDs, HIV/AIDS, a communicator with experience in HIV/AIDS and a trainer with adequate knowledge on sexuality, family skills, etc. The main **responsibility for training** would invariably be that of the NSS trainer in each of the training centres where the training programme is carried out.

At the college level, when this manual is used to provide training to a team, the responsibility will be that of the NSS programme officers. Although it is desirable to have roughly the same type of facilitators or trainers as mentioned in the previous paragraphs, it may at times be necessary to look for alternate trainers. In any case, all trainers must make themselves familiar with this manual before arriving at the training venue and strictly adhere to the steps outlined in it.

4. Some Tips for Trainers

The trainers are expected to go through the manual and its contents completely, especially the sessions, to be conducted by them. This may be supplemented by their own personal knowledge, experience and additional reading. The trainers should be **comfortable while talking about sex and related topics** as their own personal attitudes are likely to be reflected in the words, and tone of voice, all of which could affect the quality of training.

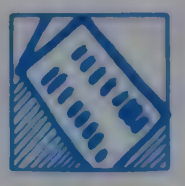
The trainers must strive to create an **informal and comfortable atmosphere,** so that the participants are at ease. They should be observant and tolerant of various reactions of participants when sensitive and delicate topics related to human relationships are discussed. For eg. some

participants may be embarrassed and could even start giggling, some may look down or away, some could create mischief like passing remarks or even exchanging notes amongst friends or use local or abusive words related to genitalia, sexual intercourse, etc. A good facilitator will accept such reactions as normal and still help the participants to be at ease and create an atmosphere of comfort without embarrassing individual's sensibilities. One **should not ridicule the trainees** or participants nor encourage them to ridicule others. The trainer **should avoid being judgemental** about any of the responses that the participants may give.

The key trainer will help the group to establish certain **ground rules right in the beginning** the training programme. All participants and trainers/facilitators **must agree on the rules to be followed** at all times during the training. Some of the issues that could be discussed while formulating ground rules could include: a. **Confidentiality** - people will perhaps be telling us certain personal and private events about themselves. How can we protect their confidentiality? b. **Smoking** - Will this be allowed during the course of the training? c. **Breaks for tea and lunch** d. How can the participants ensure that every one gets an **opportunity to speak?** These rules need to be discussed and agreed upon by all participants.

Introducing and Moderating Sessions :





For the first day, the co-ordinator should take the following responsibilities :

- Ensure that sessions begin and end on time as far as possible.
- Introduce the topic of the session and the resource persons.
- Link the session with previous ones.
- Assist the resource persons with audio-visual material and hand outs.
- Assist the session resource persons to keep track of time.
- Encourage a reasonable number of questions related to the topic; and conversely try to limit questions unrelated to the topic or those which will be answered either during group work or in later sessions.
- Ensure that the general flow of the workshop is maintained.

Undertaking a Daily Review and Overview

It is recommended that a brief review and overview session should begin **each day** to review major themes from the previous day and link them with both the overall workshop objectives and themes

to be introduced on the new day. The workshop coordinator usually takes the responsibility for **presenting the daily review and overview.** But the function might also be shared by other members of the training team. Alternatively, a participant may be identified to share the impressions from the previous day by rotation. At times, the workshop coordinator will have to, based on feedback from the participants and the training team, decide to organize one or more **evening clinic sessions.** Clinics are useful to cover **additional topics** related to the training or to go more into depth on topics covered in the larger workshop. Several topics may be suggested by participants or there may be almost unanimous agreement on one or two key topics. Choices based on priority or interest will have to be made.

Guidelines for Session Design

Objectives :

Think through and specify from the start. What specifically the session should achieve? What skills and knowledge the participants are expected to gain at the end of the session? These are included as a part of this training manual.

Learning Points

The trainers or facilitators should identify the key learning points that every participant should have understood at the end of the session.

Content :

Do not be too broad in approach. In individual sessions do not repeat what may have been said earlier in the workshop or what will later be covered by other resource persons. Use examples from experience or from information that is shared by participants to illustrate the points.

Jargon

Some participants may be unaware of much of the jargon and terms that an expert resource person may use for certain sessions. Define the terms and abbreviations and terminology that is used throughout the session.

Participative Method :

Active involvement by the participants should be the rule. Ask questions individually or in short group exercises so as to involve the participants to make the presentations more meaningful.

Discussion on Handling Awkward Questions :

- Recognize that awkward questions will be a natural corollary to any discussion or training on HIV/AIDS and sexuality.
- It is important to be prepared and gain confidence to handle such questions.
- Learn several ways of handling questions in different groups.
- Feel comfortable about the possibility of not being able to answer certain questions that the participants may raise.

How to Handle Awkward Questions :

Teasing/mocking tone - Some participants ask questions to just disconcert or embarrass the speaker. If the tone of the questioning person appears to be jeering, mocking or rude, the speaker should focus on that instead of attempting to answer the question. The speaker should **calmly and confidently reflect to the person** that his query is not serious and is only trying to embarrass the speaker and it would diminish the importance of the message (especially in the area of HIV/AIDS) that the speaker is trying to convey, if he or she allows such behaviour to continue.

Personal questions - Some participants, at times, ask personal questions such as : Do you use a condom? Have you gone for an HIV test? Have you had a particular type of sexual experience? etc. It is not necessary to provide personal information as it is not relevant in the context of learning about HIV/AIDS. However, it is equally important for the trainer or facilitator to respect the question and not be on the defensive. Hence, one can respond by being true to one's feelings by indicating that one does not feel comfortable sharing such information as it will not make the message any clearer or that it is not appropriate in the setting of the presentation to go into one's personal life or that the speaker does not want to influence the group by his or her personal choices but rather wants to give them factual, complete information so that they can choose options that are best for them. However, self disclosure at appropriate times on some aspects has its benefits. This may be on less complex matters and not on all personal matters.

Medical or detailed questions - Some questions pertain to detailed medical information or are very complex. They usually indicate a deeper interest in the subject and may go beyond the capacity of the trainer or facilitator's current information base. In such cases it is very important to validate the relevance of the questionnaire and his or her interest and to be honest in saying "I don't

know". It needs to be emphasized that the wrong or incomplete answer should not be given by the communicator in order to save face or avoid embarrassment. A trainer gains respect when he or she is honest about his or her limitations and can acknowledge it openly in a group. However, the query should be attended to by either referring the questionnaire to an appropriate expert or by the trainer noting down the question, obtaining the correct information and getting back to the participant later with the relevant information.

There are certain common problem behaviours possible ways of dealing with them.

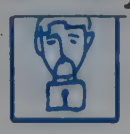
- **The monopolizer or non-stop talker.** Interrupt him or her when you can and ask for the views of others.

- **The interrupter -** As a trainer suggest that he or she should hold opinions until the person who has been specifically asked to speak has finished.

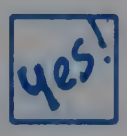
- **The rambler -** who keeps wondering off the subject. Re-phrase the comment or ask questions to bring the discussion back to the point within the group.

- **The whisperer -** who keeps distracting the group. Ask the person to share his or her ideas with the group and not with any individual sitting next to him or her.

- **The silent one -** provide opportunities for two-way discussion, if possible and watch for ways to encourage him or her to speak.



Arriving at Group Consensus



Reaching group consensus does not mean that a few people decide and the others go along with them. Reaching consensus implies substantial agreement to the conclusions of the group, even though agreement may not be necessarily unanimous. Every one must participate in the discussion; **it cannot be assumed that silent members agree.** The following may be done to reach group consensus :

- Participants should avoid arguing in an attempt to win as individuals. What is right is the **best collective judgement of the whole group.**

- Conflict about ideas, solutions, predictions, etc. should be viewed as **helping rather than hindering** the process of seeking consensus.

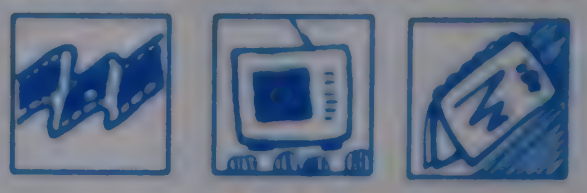
- Problems are solved when individual group members **accept responsibility** for both listening and contributing so that everyone is included in the decision.

- **Tension reducing behaviours** can be useful if meaningful conflict is not smoothed over earlier.

- The best results flow from a **fusion of information logic and emotion.** Value judgements include members' feelings about the information and about the process of decision making.

- Finally, it is not essential for a consensus to be arrived at in every group sessions.

Some of the methods during this training programme include the following :



1. Lecture
2. Lecture followed by discussion
3. Role play
4. Pictures and slides
5. Video presentation followed by discussion
6. Case studies
7. Use of flip charts
8. Group discussions and group work

The trainers should be **familiar with the various training methodologies** that are used. In this module, it will not be possible to give a detailed description of each one of these methods. However, the trainers should remember that whenever it is possible, an active participatory method of learning should be encouraged. Audio visuals such as use of transparencies, black board, flip charts, videos should find a definite place in different sessions. Some group work will require small groups of 3 to 5 individuals whereas other group activities will require upto 8 or 10 individuals. The individual methods are described or mentioned in each of the sessions of the training module. A brief description of only some of the methods will follow here.

Role Play :

In role play, participants take the part or role of some one in a situation to try out possible responses to a situation followed by analysis of the interaction by the entire group. For the purpose of understanding and/or changing one's behaviour, role plays can be built around either a hypothetical situation or can be allowed to form spontaneously around examples suggested by participants or problems that arise during training. Typically, the entire group watches and discusses a single role play. But, if the group is familiar with the process, multiple role plays can take place simultaneously.

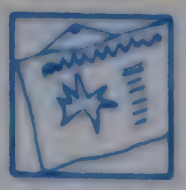
Role plays engage the group in real life problem without involving them in the same level of risk and thus provide opportunities to try out new approaches safely with **feed back** aimed at helping the person see what he or she can do differently. Role play also allows one to experiment with the unpredictable emotions and to deal with feelings that are not always brought into discussion, case study or analysis.

Some participants, at times, resist involvement in role plays. Possibly because their behaviour is open to observations and criticisms by other participants. The value of role play increases with the skill of the facilitator in helping the group analyze what took place without falling into the trap of negative criticism and in leading the group to see the interaction in terms of the objectives of the session. Observations/guidelines are helpful for this reason since comments are focussed on specific points for discussion. Therefore before the role play begins, the facilitator, for certain exercises, may like to identify key areas or issues to be observed and to be discussed once the role play is over.

The facilitator should brief each group thoroughly on the situation, suggesting that participants play their parts as naturally as possible, putting aside an exact script in favour of what they think a person in that role might do or say. People might keep in mind a particular person whom they know and think in terms of how he or she would respond.

Under most circumstances, the role play should not take more than 10 to 15 minutes, since it is crucial that time be spent on analyzing what took place. The rest of the group should be asked to observe or to jot down notes and be prepared to actively join the discussion. Start processing the role play by asking group members themselves to comment on points of observations or the check-list or issues which have already been identified and briefed earlier. Most of the time, group members will themselves be aware of the meaning of what took place, and it helps them to be less defensive. Ask them to first comment on things they felt good about and things they would have liked to do differently. Then, open the discussion to everyone asking them again to comment on

both - what was positive as well as what could have been done differently. Finally **draw connections to the larger issues** addressed by the particular session.

Pictures and Slides : 

Pictures and slides can be used in many ways especially when working with youth groups or as part of community projects. They are useful to draw people's attention to a topic and to start discussion and stimulate group participation. They also help people to remember what you are presenting and to illustrate a point that you want to make.

You can use pictures or photographs as part of a game such as the memory game, and to convey messages on posters and displays. Pictures and photographs can be used to present a specified situation or problem, the causes and suggest possible actions for solution.

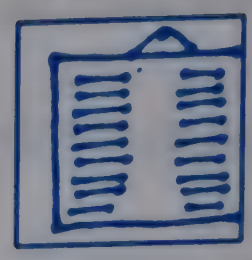
While selecting pictures or slides to use as part of a presentation, activity or project, the pictures and photographs should :

- show local situations and people who look and dress like local people
- Focus on one main idea to avoid confusion
- be large enough for the group to see easily
- be clear enough to be easily understood

It will be important to present any pictures you plan to use for educational purposes and for information sharing projects such as posters and display boards.

Case Studies : 

Case studies describe a situation or problem that the group has to solve. They can be designed to give people information, help them to consider their attitudes and values and discuss the skills they might need to deal with the problem. For eg. there can be very simple stories which ask the group to think of strategies they might use to solve a situation: Fernando died of AIDS recently. Now, no one will go near his wife and children and some people are suggesting they should be made to leave the village. What should be done to help Fernando's family and the villagers? Or they can be much longer and have more characters who face difficult problems or situations. Remember, that your group may have difficulty in reading. You may have to read the case study to them very slowly. Don't make it so complicated that they forget who did what, when and how. It is a good idea to go over the main points to make sure everyone has understood.



CHAPTER 2

TRAINING SCHEDULE

The schedule proposed for the training seeks to help realise the UTA objectives effectively, by fullest understanding and involvement of the functionaries with the issue to which UTA seeks to address itself. The potential trainer may go through the following points before studying the training schedule :

1. The proposed schedule is a four day residential training programme. Residential training is recommended in order to get a full time involvement and commitment of the trainees to the programme. It provides for late evening activities that could help in community building in the trainee group as well as provide opportunities for learning. It will give the group more opportunity to be together and get to know one another, thus creating a climate for better interaction on sensitive and intimate subjects crucial to the understanding of HIV/AIDS. This will be more applicable to a group where members do not know each other. However, at the college/school level the training programme **need not be residential.** Adequate and appropriate use of ice breakers and warm ups is necessary to help build the conducive climate for training. Some examples of ice breakers and warm ups are given in Annexure -1.

2. The training schedule provides time for warm ups regularly during the programme. The purpose of providing these is to keep the energy levels and group feeling high to facilitate participation. The trainer can reschedule these according to the needs of the group.

3. The programme begins with preliminaries. This session should be seen as **a crucial investment to build the environment** for the training programme. The objectives of the session are :

   (i) To know the level of knowledge and attitude of the trainees on the subject of AIDS and their expectations from the training programme.

   (ii) To 'break the ice' in the group and create an informal and relaxed atmosphere.

(iii) To provide the context of the training to the group.

There is no provision for a formal inauguration. This has been deliberately avoided as it quite often gives a formal touch to the programme, which is likely to adversely affect the training environment. Besides, it is also likely to distract the attention of the trainers towards formal arrangements for the function, and not allow them to devote their **undivided attention to the training itself.** However, if one does feel the need for associating dignitaries with the programme, it may be done at a valedictory function.

4. The training schedule will be easier to follow if some standard training arrangements are made in advance. For example :

i. A well ventilated room with adequate lighting arrangement.

ii. The room should allow easy shifting of furniture, to permit arrangements as may be required for different exercises in training.

iii. Circular seating arrangement with single or double rows depending on the size of the room/size of the group.

iv. Blackboard and chalks or white-board and markers or chart papers and thick markers.

v. Display board.

vi. Cello tape, scissors, chart papers, felt pens, stapler, paper and other such stationery items must be kept handy.

vii. Slide projector and overhead projector.

viii. Projection screen if available.

ix. Colour television and video cassette player, wherever available.

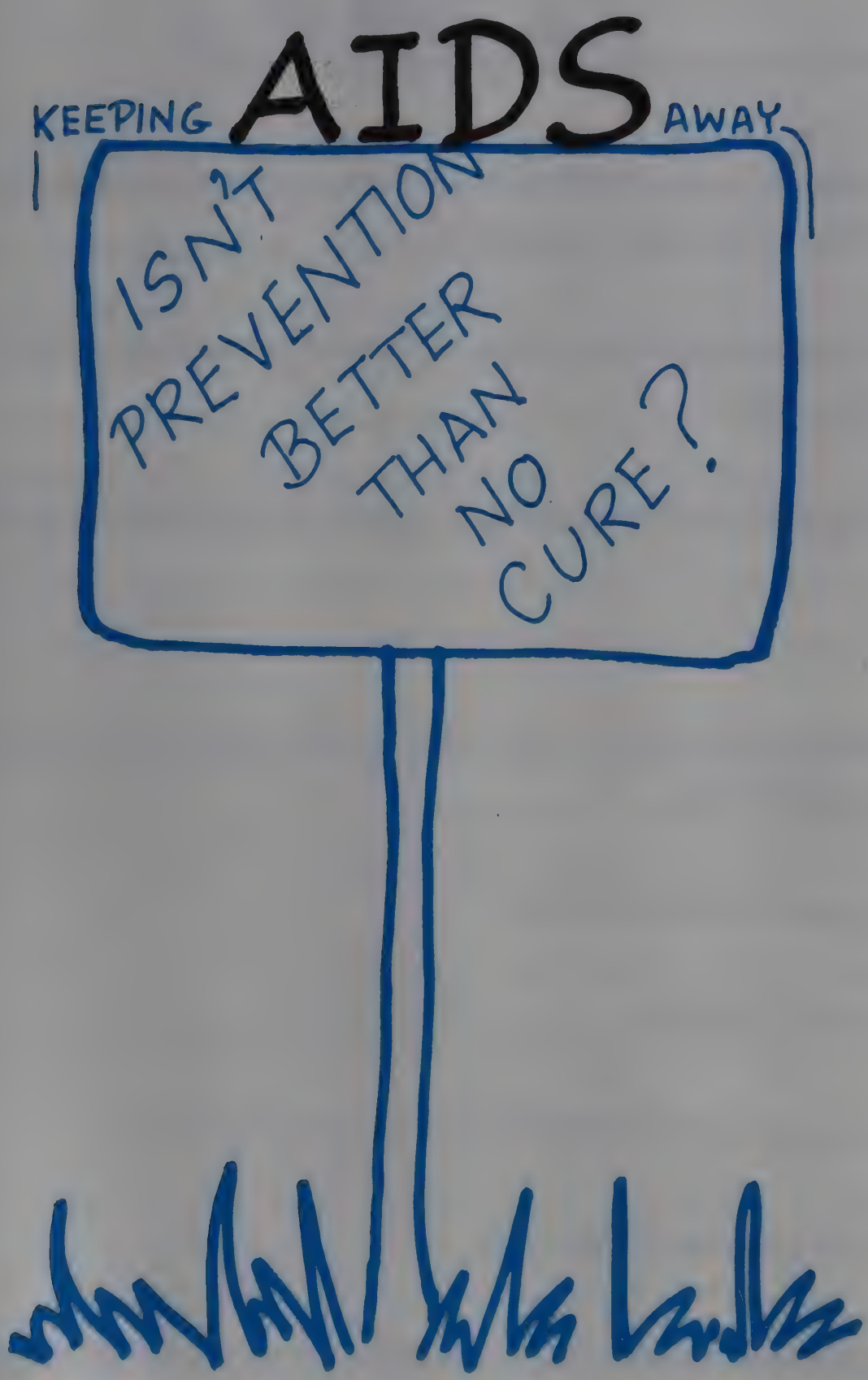
x. Drinking water for trainees and trainers.

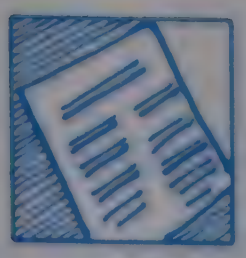
xi. A question box, where trainees could put their questions which they do not feel free enough to ask or have no time to ask.

5. Some tips/information for the entire training programme should be **sent to the trainees before they come for the training.** Along with this, a proper training schedule needs to be chalked out.

Besides the above, the trainer must ensure that training materials like slides, video cassettes, response sheets, sorting cards, etc. are available in advance.

This training schedule provides for giving basic inputs to equip college level functionaries with AIDS education to undertake the project. Though the schedule is flexible to some extent, care must be taken not to disturb the sequence or the content of the programme.





TRAINING SCHEDULE

The training schedule proposed is as follows :

Daily
Tea break :10.00 a.m. to 10.15 a.m.
Lunch break : 1.00 p.m. to 2.00 p.m.

Day and Time	Content
First Day	
08.30 a.m. - 11.00 a.m.	**PRELIMINARIES**
08.30 a.m. - 09.00 a.m.	Registration & trainee to fill Pre-training Response Sheet
09.00 a.m. - 9.30 a.m.	Opening remarks (UTA Project)
09.30 a.m. - 10.00 a.m.	Ice breakers
10.15 a.m. - 10.40 a.m.	Training programme
10.40 a.m. - 11.00 a.m.	Establishing ground rules during training
11.00 a.m. - 01.00 p.m.	**HIV/AIDS: Issues and facts**
11.00 a.m. - 12.30 p.m.	HIV/AIDS: The facts
12.30 p.m. - 01.00 p.m.	Youth and HIV/AIDS
02.00 p.m. - 05.00 p.m.	**HUMAN SEXUALITY**
02.00 p.m. - 02.45. p.m.	Concept clarification
02.45 p.m. - 03.30 p.m.	Sexuality: Misconception and beliefs
03.45 p.m. - 04.30 p.m.	Growing up process in Boys and Girls
04.30 p.m. - 05.00 p.m.	Sexually transmitted diseases

Second Day

09.00 a.m. - 10.00 a.m.	Responsible sexual behaviour
10.15 a.m.- 05.00 p.m.	**PSYCHO-SOCIAL ASPECT OF HIV/AIDS**
10.15 a.m. - 11.30 a.m.	AIDS and You : Value attitudes clarification
11.30 a.m. - 12.30 p.m.	Impact of HIV/AIDS
12.30 p.m - 01.00 p.m.	Video Film
02.00 p.m. - 03.30 p.m.	Wild fire game
03.45 p.m. - 05.00 p.m.	Counselling and referral skills

Third Day

09.00 a.m.- 05.00 p.m.	**PREVENTION OF HIV/AIDS AND PREVENTIVE BEHAVIOUR**
09.00 a.m.- 10.00 a.m.	Role of behaviour in transmission of HIV/AIDS (High Risk, Low Risk)
10.15 a.m. - 11.00 a.m.	Assessment of Risk behaviour
11.00 a.m. - 12.00 noon	Taking risks and making choices
12.00 noon - 01.00 p.m.	Skills for adoption of preventive behaviour
02.00 p.m. - 02.45 p.m.	Skills for adoption of preventive behaviour (cont'd)
02.45 p.m. - 03.30 p.m.	Safer sex: Condoms
03.45 p.m. - 05.00 p.m.	Benefits of long term monogamous relationship

Fourth Day

09.00 a.m. - 10.00 a.m.	**COMMUNICATION SKILLS** Need and objective of communicaton
10.15 a.m. - 01.00 p.m.	**ACTION PLAN DEVELOPMENT**
02.00 p.m. - 03.00 p.m.	Presentation of work plan

TRAINING MODULE I

HIV/AIDS:
ISSUES AND FACTS

CHAPTER 3

TRAINING MODULE I

HIV/AIDS: ISSUES AND FACTS

Duration: 2 Hours

Subsections

I. HIV/AIDS : The Facts

II. Youth and HIV/AIDS

Learning Objectives :

1. To raise awareness and improve knowledge of HIV/AIDS.

2. To create self-awareness among participants and make them realise that they are personally concerned with HIV/AIDS and sexually transmitted diseases.

3. To enable participants to understand and perceive the risk situations that lead to HIV infection and sexually transmitted diseases (STDs)

4. To improve knowledge of HIV/AIDS through continuous information.

Module:I

Subsection:I

Duration: 1 hr. 30 min

INTRODUCTORY TIPS ON HIV/AIDS : THE FACTS

Objective:

Increase knowledge of basics of AIDS

Method:

Discussion cum lecture (question and answer session)

Material Needed : Flip charts/Overhead Projector (OHP) / slides, blank paper, pens.

Notes to the Facilitator :

1. This session is divided into a series of questions. The answers to these questions are backed up by slides which can be easily transferred to flip charts/OHP transparencies. It is expected that the group answers from its existing knowledge about HIV/AIDS and the facilitator would then give the correct answer with the help of slides. You could also use the answers from the true-false exercise to facilitate group action/discussion.

2 Explain to the group that this is not an examination but a process to understand the facts about HIV/AIDS.

3 At the end of the exercise hand over a response sheet of the true-false exercise as well as the leaflet, **Learn to stop AIDS.**

Questions and Discussion Points :

1. *What is AIDS ?*

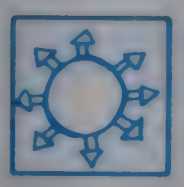
AIDS is a medical diagnosis for a combination of symptoms which results from a breakdown of the immune system. AIDS stands for Acquired Immune Deficiency Syndrome. The immune

system defends the body against infections and diseases. The immune deficiency is caused by infection with a virus. 'A' stands for Acquired which means that it is obtained or received by a person and is something which does not ordinarily exist within one's body. 'ID' stands for immune deficiency which means there is a deficiency in the immune system or that the immune system is weakened. 'S' stands for syndrome which means AIDS is not one particular isolated disease but one which has a variety of symptoms leading to various disorders and a set of diseases.

2. *What causes AIDS ?*

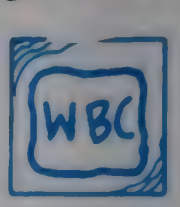
AIDS is caused by a virus. It's name is HIV (Human Immuno-deficiency Virus). As the name suggests HIV weakens the immune system or the body's own defence system. This process is slow and usually takes years after the infection for a person to notice that he/she has been infected, when the effects of the weakened immune system manifest themselves.

3. *What is HIV or what does it look like ?*



HIV is not a single virus. So far, two viruses have been identified to cause AIDS-HIV1 and HIV2. HIV belongs to a family of viruses called Retroviruses. HIV is tiny, a thousand times smaller than the thickness of a hair, it looks like a rolled up porcupine, it contains two snake-like single strands of Ribose Nucleic Acid(RNA) along with a reverse transcript which lies firmly wrapped up in a core which resembles a cone with a dimple at its base. This cone is protected by an envelope which has a knob- like protein sticking out its surface, giving HIV it's characteristic appearance.

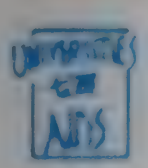
4. *What is the immune system ?*



In healthy individuals, infections are kept at a distance by virtue of an array of defenders of the body which constitute the immune system. The most important components are the White Blood Cells present in the blood and lymphatic system including the lymphglands. Unknown to us these defenders are at work day and night, recognizing foreign invaders in the body and fighting them by producing an army of cells which attack the infection directly and produce antibodies which neutralize/kill the invaders.

5. *How does HIV weaken the immune system ?*

How exactly HIV weakens the immune system is still being researched. According to the most accepted theory, HIV directly attacks the white blood cells. HIV zeroes in on white blood cells called CD4 cells which play a vital role in controlling the immune system. These cells have an ability



to communicate to each other. In this case the HIV enters the white blood cell. Upon entry it hijacks the genetic constitution and partly replaces it by its own sensitive information and then multiplies. These cells now attack other white blood cells. Slowly the number of white blood cells in the body is reduced and the immune system is paralysed. HIV remains practically immune to counter attacks, since it hides inside the attacked cells which are also the cells that are supposed to attack HIV.

6. What does HIV+ve mean ?

It means that the person has the HIV virus and is harbouring a HIV infection. Such an individual is also identified as a seropositive individual for the HIV virus. This person does not as yet suffer from the syndrome or the disease complex, AIDS.

7. What happens when a person is infected with HIV ?

When a person is infected with HIV nothing is visible on the exterior but it is possible for the person to still infect others.

8. Does HIV+ve mean a person has AIDS?

A person with HIV may initially be perfectly healthy but will eventually develop AIDS. In the meantime he/she may continue to appear healthy like others. A person with HIV is called "having AIDS" when his immune system is totally broken down and does not respond to treatment.

9. Who can get AIDS or the HIV?

AIDS has to be acquired. It has to be passed on from one person to the other either by sex or blood transfusions, or from infected mother to unborn child. It is difficult to get, but one has to take the necessary precautions. AIDS does not discriminate by sex, religion or caste.

10. Can you identify an HIV+ person by looking at his/her face?

No, It is not possible to identify a person by looking at his/her face. Being clean or dressed properly does not mean that the person cannot have the HIV virus.

11. *Where did AIDS come from ?*

No one knows where AIDS came from. It is however important to note that it is now present in the country and spreading. One has to learn to protect oneself.

12. *How does a person become infected with HIV?*

The medium of transmission is blood or sexual secretions(semen, vaginal or cervical secretions)

There are only four known ways or routes of transmission of the HIV virus :

- Having sexual intercourse with an infected person.
- Transfusion of infected blood or blood product.
- By infected blood in syringes and needles and body piercing intruments.
- By an infected mother to her unborn child.

13. *Is AIDS also an STD ?*

Yes it is, but unlike most other STDs it is not curable. Having other STDs increases the risk of getting or transmitting HIV or chances of getting HIV is greater when you have an STD.

14. *How is HIV spread through sexual contact ?*

Infection with HIV through sexual relations is possible by the following direct contacts :

i. Contact between the penis and vagina in heterosexual intercourse.

ii. Contact between penis and the rectum in anal intercourse between man and woman (heterosexual) or man and man (homosexual).

iii. Contact between seminal fluid (possibly also vaginal secretions including menstrual blood) and the mucous membranes of the mouth in oral (mouth to genital organs) intercourse (heterosexual and homosexual)

iv. A woman has a greater chance of being infected by an HIV infected male than a man being infected by an HIV infected woman. This is because the contact period between the seminal secretions and the female's body is longer than the contact between the vaginal secretions and the male organ.

15. *How is HIV spread by infected blood through needles/syringes or other equipment?*

Used needles and syringes are always soiled with minute amounts of left over blood. Infected blood will directly transfer HIV into the blood stream.

16. *How is HIV spread from an infected mother to an unborn child?*

HIV may be communicated during pregnancy or childbirth if the mother is HIV+ve. Children born of HIV+ve mothers are likely to be infected with the virus. There is 30% chance that it will be passed on to the unborn child.

17. *How is it spread by blood transfusion ?*

Transfusion of infected blood from one person to another would directly transmit the HIV into the blood stream of the recipient. The chances of passing on the HIV in such a situation is close to 90%. Blood donation has no risk of acquiring HIV infection, one should donate blood regularly. It is safe to donate once in 3 to 4 months and increase the pool of uninfected blood and thus ensure safe blood for yourself, your relatives and others in your area. Donating blood voluntarily by youth who are not infected and who are healthy is a safe practice which should be encouraged.

18. *What is the main route of spread of HIV ?*

The most common route of HIV is through heterosexual sex. It accounts for nearly 80% of the world's AIDS cases. The next important route is injecting of drugs.

19 *How can one protect oneself from HIV/AIDS ?*

A major route of transmission being sex,

- The youth would need to abstain from penetrative sexual contact. This may be done by adopting other safer intimacy option which include hugging, cuddling, massage, mutual masturbation, kissing etc. Penetrative sex of various kinds including vaginal, oral or anal

sex should be avoided. Abstain from sexual intercourse, i.e.sexual penetration, vaginal, oral or anal.

- Have sexual intercourse only with a faithful uninfected partner.
- Practice safe sex when there are more than one sexual partners. Use a condom in all types of penetrative sex.
- Reduce the number of sexual partners.
- Avoid sex with people who have many partners.
- If you use needles, syringes or other instruments that pierce the skin , make sure they are sterile.
- Never share needles and syringes.
- Make sure blood is tested before transfusion. Use blood that is certified HIV free.
- Avoid pregnancy if infected with the HIV virus.

20. *How can you test for the presence of the HIV virus ?*

There are two tests, Elisa and Western Blot test. Both these tests detect antibodies to HIV and not HIV itself. Antibodies are produced by our body's defence system to fight against intruders like viruses and germs. These antibodies detect attack and destroy unwanted intruders. There are antibodies against the HIV too but these are powerless to destroy the HIV.

i. How long after infection does it take for the body to reveal the presence of antibodies?

It takes about 6 weeks to 3 months to reveal the presence of the HIV in the body.

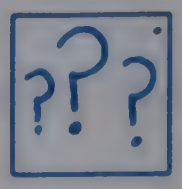
ii. How long after infection does it take to develop AIDS ?

In 50% of those who are HIV+ve, it takes ten years to develop AIDS but it is faster in societies where the health and nutritional status is low.

iii. Limitations of the tests and how it is carried out ?

The test may indicate false positive from time to time because of the window period in which the presence of the antibodies is not detected.

21. *What does this test mean or tell you ?*



It tells you whether antibodies to the virus are present in your body or not.

The HIV antibody test tells you about the past but it is no guarantee against the future. You could still get infected if you do not understand the risks and do not take necessary precautions. A very recent infection cannot be detected by the test.

22. *How can you not get the HIV virus ?/ What are the misconceptions people have regarding AIDS?*

You cannot get the HIV by :

- Shaking hands, embracing, contacts with objects in phone booths, public transport, doorknobs, money.
- Shared use of china crockery, silver, glasses, towels, bedding,linen, toilet articles.
- Eating and drinking from communal dishes(e.g. fondue or Holy Communion).
- Caressing, petting, kissing.
- Masturbation.
- Coughing, sneezing, tears.
- Normal use of public toilets, swimming pools,community showers, saunas(unless unsafe sex is practiced there).
- Medical treatment in hospitals, in doctor's and dental clinics and in all therapy situations where normal rules of hygiene are observed.

- Massage, physical therapy, cosmetics (cosmetic treatment), hairdresser, accupuncture, piercing of ears and other comparable treatments, as long as normal standards of hygiene are maintained.

- Donating blood.

- Scratches and bites by pets.

- Caring for AIDS victims or HIV positive people.

Module : I **Duration: 30 minutes**

Subsection : II

YOUTH AND HIV/AIDS

Objectives :

- To learn about the spread of HIV/AIDS in the country and globally.
- To learn the importance of youth action on AIDS.

Method : Small group discussion/presentation

Material Needed : Flip charts/slides & slide projector/ transparencies & OHP, blank chart paper and pens.

Group Size : 30

Notes to Facilitator :

1. Introductory remarks : It may be useful to start the session by saying the following sentences.

   All of us are familiar with the term AIDS but few have the right knowledge regarding what the disease is, how it is spread and what could be done to prevent it. The extent of the problem has not been realized by all. However, one thing that AIDS has instilled in every man is fear. This disease has spread all over the world and is now in India, too. Since the predominant channel of infection is sexual, the youth are considered a high risk category. But the redeeming feature is that the youth are also extremely influential in shaping the behaviour of their peers against HIV/AIDS.

2. After these remarks tell the group that you would now ask them a few questions on the basis of which the discussion would proceed. It may be useful to write down all the responses of the group on the following questions on a chart paper or flip chart.

   i. Do you think it is an important concern ? Why ?

ii. How many people in your state / town are infected with HIV ?

iii. How is HIV transmitted in our country ?

iv. How many AIDS cases have been reported so far in our country ?

3. After writing down the responses use the following slides to explain the situation with regard to the problem of HIV/AIDS in the world.

Slide 1: Estimated distribution of cumulative HIV infection in adults by continent or region (Late 1993)

Explain that out of the 1.5 million persons with HIV+ve estimated in southeast Asia One million are estimated to be in India alone.

Slide 2: Distribution of estimated and projected annual adult AIDS cases

This slide should be used to point out that the increase in the number of AIDS cases in Asia is showing the same trend as in Africa. Since the first reported case of AIDS in the Asian region was in the late 80s it is estimated that the graph for Asia ten years later would look exactly as the graph for Africa stands now. While there will be a decline in the number of AIDS cases in the other continents, the number in Asia would only increase in the next few years.

(The facilitator could also point out the differences between the first and the second slide by stating that the first was of HIV infection and the second of AIDS cases. The difference between AIDS & HIV infection should be made clear from this slide.)

Slide 3: Reported and estimated cumulative adult AIDS cases, late 1993

This slide should be used to point out the difference between reported figures and estimated figures. For every reported case there are more cases which are not reported and hidden. The low incidence of reporting should not be taken as an indicator for prevalence in any part of the country.

Slide 4: HIV transmission - Global summary 1991

This slide should be used to explain the various routes of transmission of the HIV infection and the percentage of infection each route would contribute to the total number of infections in the country.

Slide 5: HIV transmission in Southeast Asia, 1992

This slide should be used to explain that the main mode of spread of the HIV infection in India would be the sexual route. However in places like Manipur, it is injecting drug use.

Slide 6: HIV Infection and AIDS

Use this slide to introduce STDs and their link to AIDS. Also mention that the new rising concern is the increase of injecting drug use among the youth population which is adding to the increase in the rate of transmission. In the last thirteen years experiences from all over the world have strongly indicated that STDs and injecting drug use greatly enhance the chances of transmission. Many injecting drug users also resort to high risk sexual behaviour. This creates a complex situation. The interventions in many parts of the world including India have shown that instilling fear has not worked and that we have to treat the problems with positive attitudes.

Slide 7: Sexually Transmitted Diseases

This slide should be used to explain that STDs spread through sex and that AIDS is also an STD. But unlike other STDs which can be cured, AIDS cannot yet be cured. The only way of protection from an STD is the use of condoms.

Slide 8: Thailand - Increase in condom use and decrease in STDs

Use this slide to illustrate that consistent condom use brings down the level of STDs prevalence substantially. This indicates that if STDs rates can be reduced, the rate of prevalence of HIV/ AIDS can also be reduced.

Slide 9: HIV epidemic in India

This slide should be used to show how HIV has spread in the country and that today it is present in all states of India. In the year 1986, HIV was first found in Tamilnadu, thereafter in Maharashtra

and Manipur. By the year 1990 it had spread to almost half of India and by 1993 all states and UTs of India have reported cases of HIV/AIDS. As of today there is no part of the country which can be described as being free from HIV/AIDS.

Slide 10 : Projections of HIV prevalence and cumulative AIDS cases in India

Use this slide to show the increase in numbers of HIV and AIDS cases in India from 1991 onwards.

4. After discussing the above points ask the following question and note the responses.

To what extent do you think AIDS will affect young people or do you think that youth are a vulnerable group? Why ?

After the responses have been written down, discuss them with the help of the following slide.

Slide 11 : Youth and AIDS, The Problem

Use this slide to give a brief description about what youth feel about the HIV/AIDS problem.

Slide 12 : Population projection

Use this slide to illustrate that youth in the age group 15 - 20 years constitute nearly one third of the population. Majority of the infected individuals belong to the age group 20-45 years which is approximately another 30% of the population. 10 years from now, the individuals who are between the ages 5 and 20 will be in the age group 10-25 and those in the age group 20-45 years will be in the age group 30-55 years. While those in the age group below 20 years have not formed their behaviour patterns, those in the age group above 20 years have formed their risk behaviour patterns. It is, therefore, possible to educate and prevent the youth in the age group 15-20 years to form their behaviour on the basis of information and knowledge related to HIV & AIDS transmission. Thus, over a period of time, we could attempt to create a healthy population in this country if we concentrate on educating the youth and the younger population about HIV/AIDS transmission. Simultaneously, those in the age group 20-45 years would require special attention to prevent further transmission of the disease and adopt safer lifestyles to prevent the infection load in the country.

5. Ask the group what are some of the factors that lead youth into high risk group situations/ behaviours. Write down all responses and discuss with the help of Slide 13.

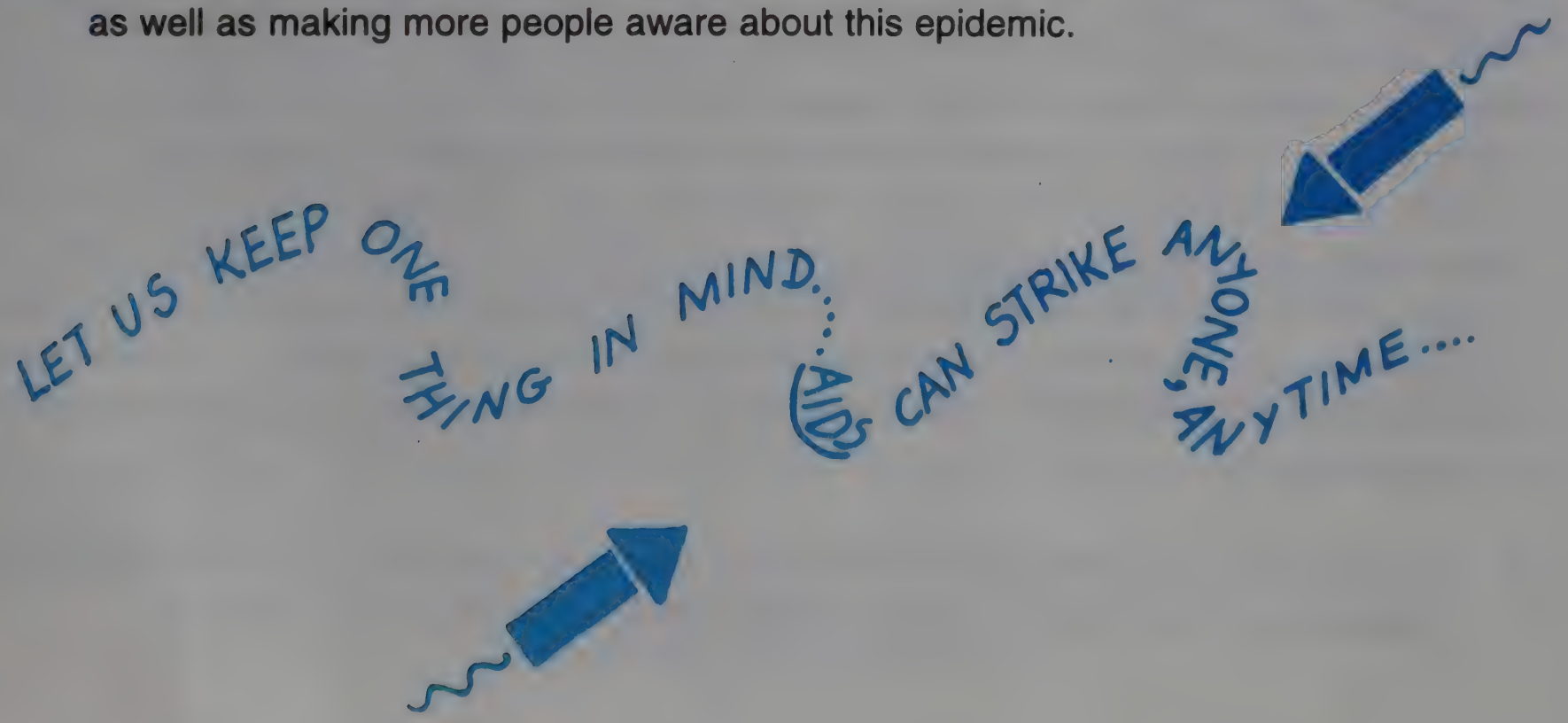
Slide 13: Factors which lead youth into high risk situations

6. Ask the group what motivated them to join this training programme. Note the responses and then discuss that they can play an important role in the prevention of the epidemic in the country.

Slide 14 : Three major intervention strategies about HIV/AIDS (to discuss the role of youth in the programme)

7. Summarise the session with the help of the following points

- Total number of infections worldwide is estimated at 10 to 12 million in adults and 5 to 10 million in children.
- In India, it is estimated that there are 1 million people infected with HIV.
- Youth in their early twenties would constitute an estimated 20 to 30 per cent of all the cases which are HIV+ve and they were probably infected during adolescence.
- To protect youth from mental and physical health problems including HIV infection, the solution lies in changing behaviour and attitudes and this can be done through systematic knowledge dissemination related to HIV/AIDS/STDs and sexuality.
- Youth have in the past shown tremendous flexibility to adopt behaviour and take suitable action.
- Youth have a tremendous role in preventing the spread of HIV by protecting themselves as well as making more people aware about this epidemic.



SLIDE 1

Estimated Distribution of Cumulative Adult HIV Infections
Late 1993

Global total : 14 million +

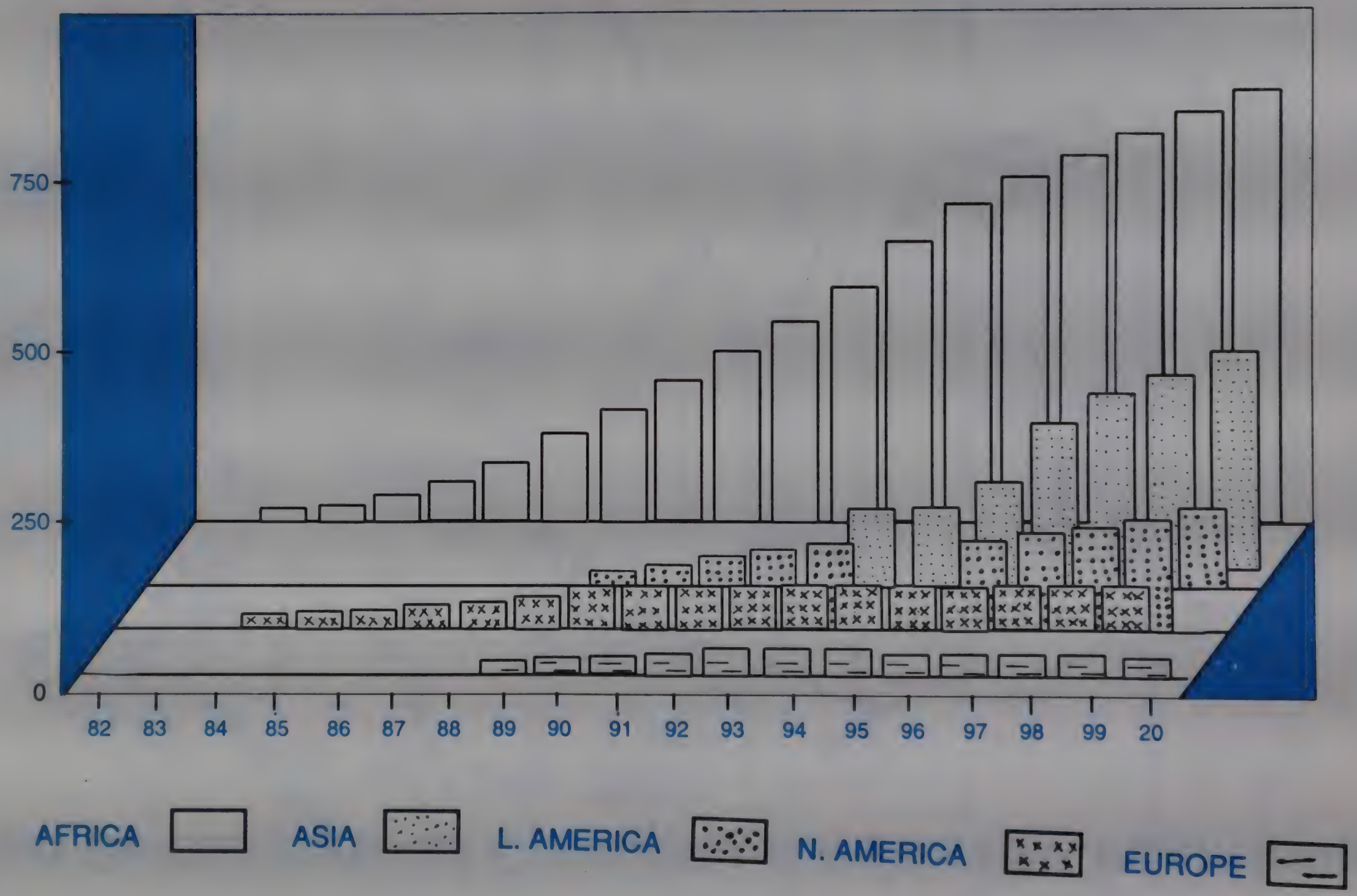
Total mondial : 14 million +

WHO - Global Programme on AIDS

GPA : OED : GMS : 94023 27 January 1994

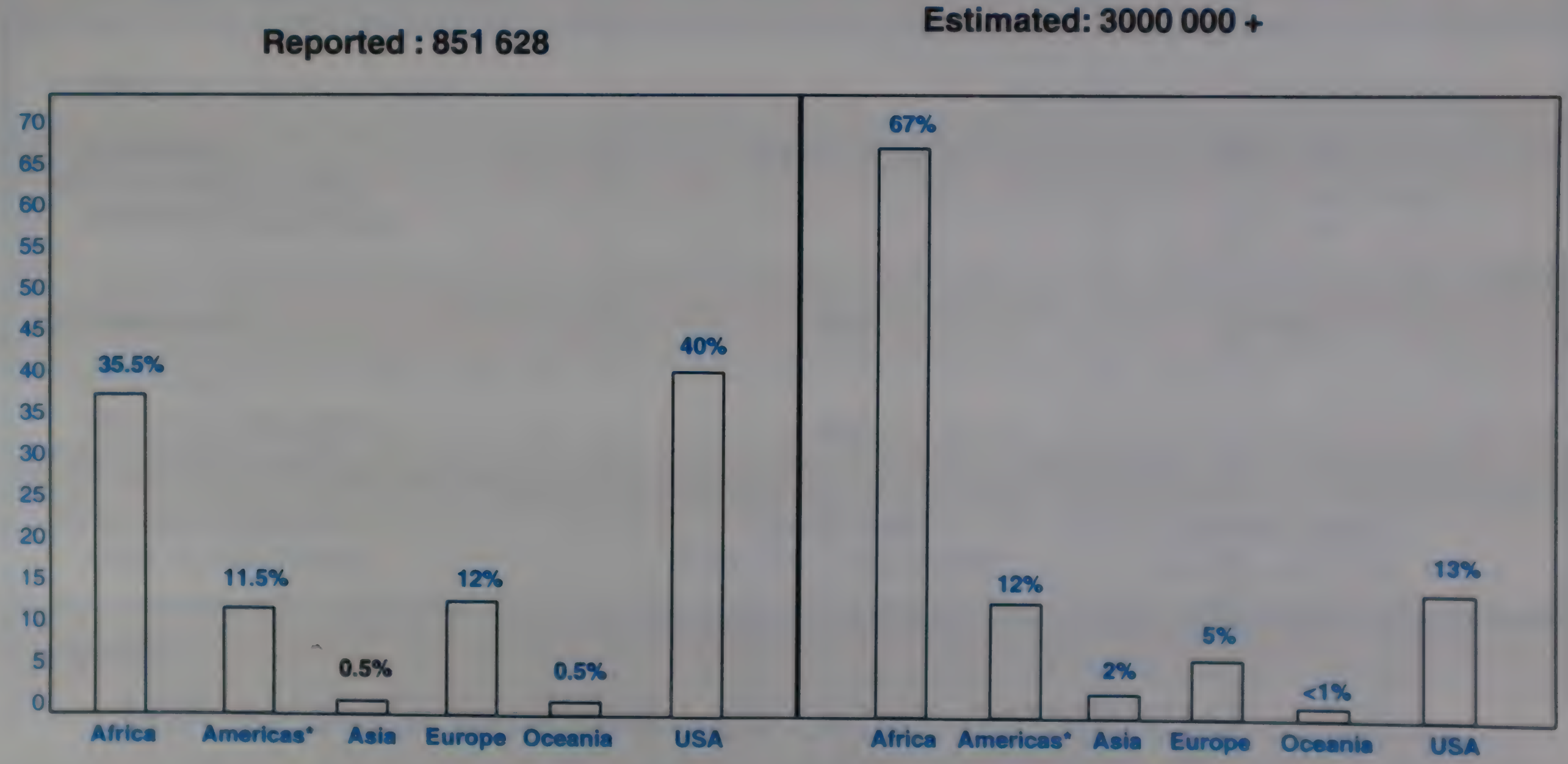
SLIDE 2

DISTRIBUTION OF ESTIMATED AND PROJECTED ANNUAL ADULT AIDS CASES



SLIDE 3

Cumulative AIDS cases in adults and children Late 1993



* Excluding USA

SLIDE 4

HIV TRANSMISSION : GLOBAL SUMMARY - 1991

TYPE OF EXPOSURE	EFFICIENCY PER SINGLE EXPOSURE	PERCENTAGE OF GLOBAL TOTAL
BLOOD TRANSFUSION	90%	3 — 5
PERINATAL	30%	5 —10
SEXUAL INTERCOURSE (VAGINAL) (ANAL)	0.1% — 1.0%	70 — 80 (60 — 70) (5 —10)
INJECTING DRUG USE-SHARING NEEDLES, ETC.	0.5% — 1.0%	5 — 10
HEALTH CARE-NEEDLE-STICK, ETC.	0.5%	0.01

SLIDE 5

HIV TRANSMISSION IN SOUTH-EAST ASIA, 1992

ROUTE OF TRANSMISSION	EFFICIENCY	% OF TOTAL
SEXUAL INTERCOURSE	0.1 — 1.0%	80 — 90%
BLOOD		
TRANSFUSION	> 90%	3 — 5%
INJECTING DRUG USE	0.5 — 1.0%	5 — 10%
EQUIPMENT/NEEDLES	< 0.5%	<0.1%
PERINATAL	15 — 45%	< 0.1%

SLIDE 6

HIV INFECTION AND AIDS

10 YEARS INTO THE EPIDEMIC

LESSONS LEARNT

— HIV IS MOSTLY SEXUALLY TRANSMITTED-75-80%

— STDs FACILITATE THE ACQUISITION AND TRANSMISSION OF HIV INFECTION

— PREVENTION OF STDs ALSO PREVENTS HIV/AIDS

— THE GLOBAL EPIDEMIOLOGICAL SITUATION

A WARNING FOR INDIA

— 10 YEARS EXPERIENCE WITH INTERVENTIONS :

MISTAKES AND SUCCESSES

SLIDE 7

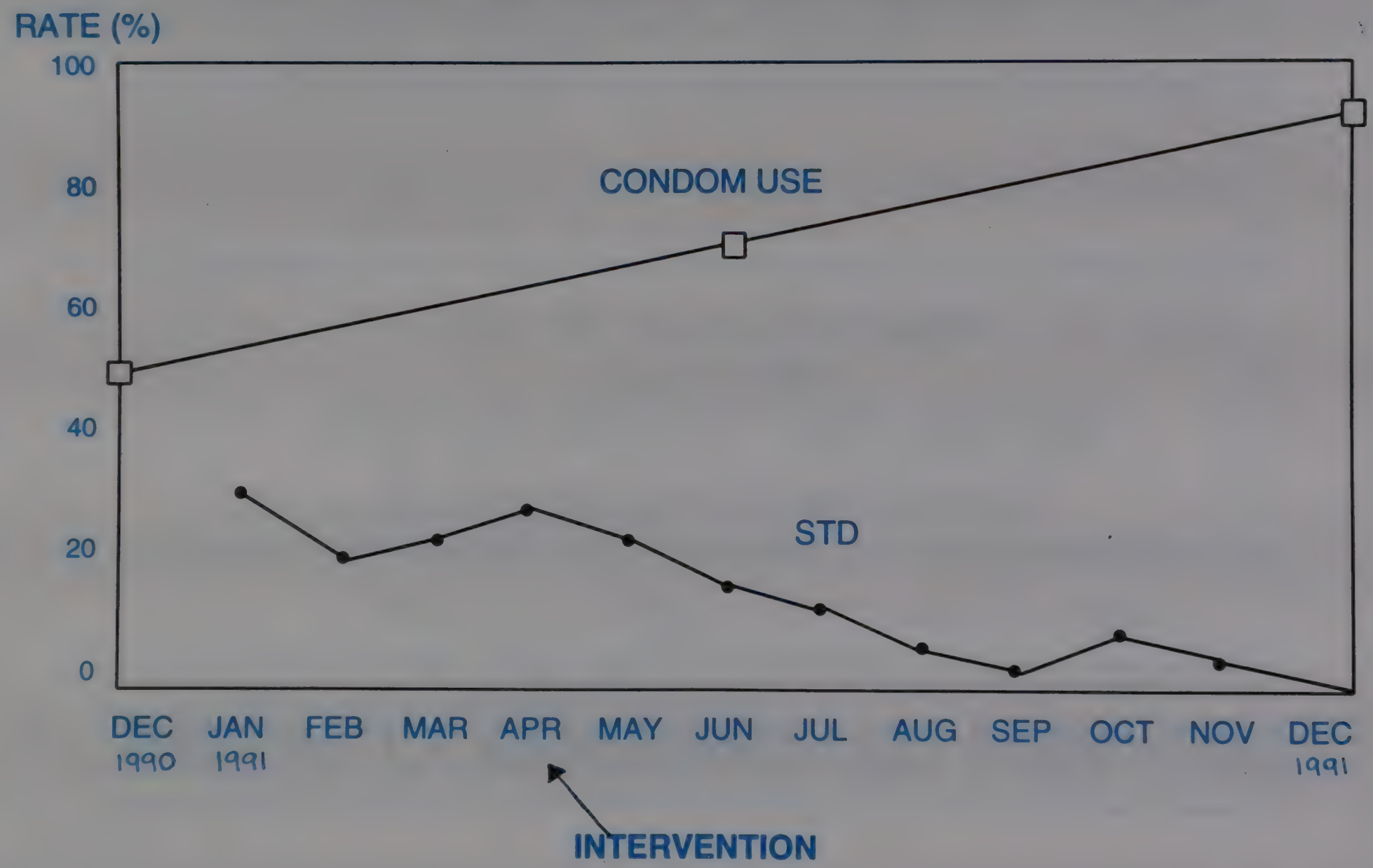
SEXUALLY TRANSMITTED DISEASES

STDs ARE THOSE DISEASES
THAT ARE MOSTLY TRANSMITTED
THROUGH
SEXUAL INTERCOURSE

THERE ARE MANY STDs,
OTHER THAN GONORRHOEA AND SYPHILIS WHICH CAN
CAUSE VAGINAL DISCHARGE OR GENITAL ULCERS

SLIDE 8

THAILAND — INCREASE IN CONDOM USE AND DECREASE IN STDs AMONG SEX WORKERS DURING "100% CONDOM" INTERVENTION



Rojanapitahyakorn W., Department of Communicable Disease Control, Ministry of Public Health, Thailand, 1992.

SLIDE 9

HIV EPIDEMIC IN INDIA

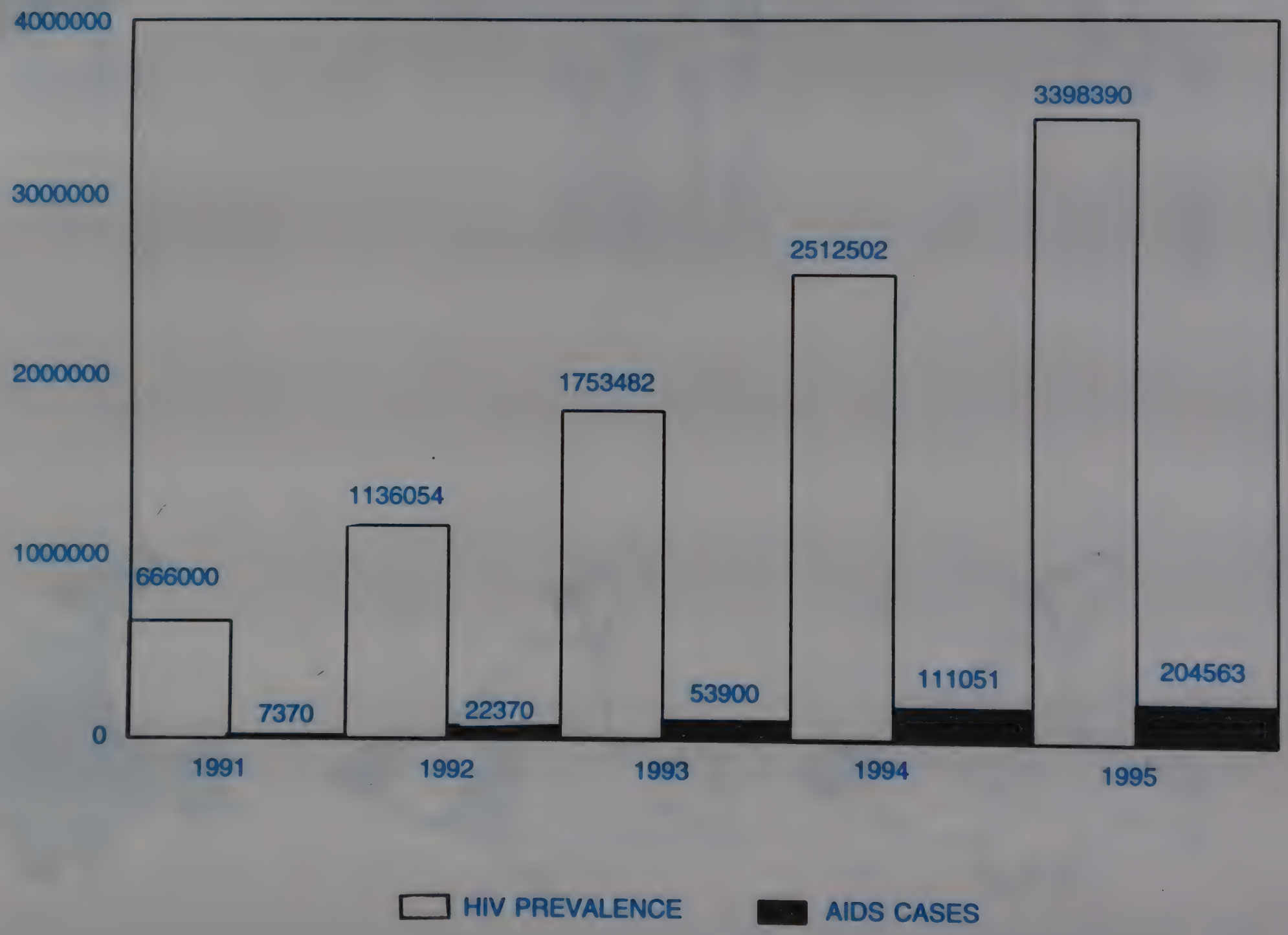
1986 — HIV EPIDEMIC IN TAMIL NADU

THEREAFTER — HIV EPIDEMIC ALSO IN MAHARASHTRA AND MANIPUR

1994 — HIV EPIDEMIC IN ALL INDIAN STATES

SLIDE 10

PROJECTIONS ON HIV PREVALENCE AND CUMULATIVE AIDS CASES IN INDIA



SLIDE 11

YOUTH AND AIDS

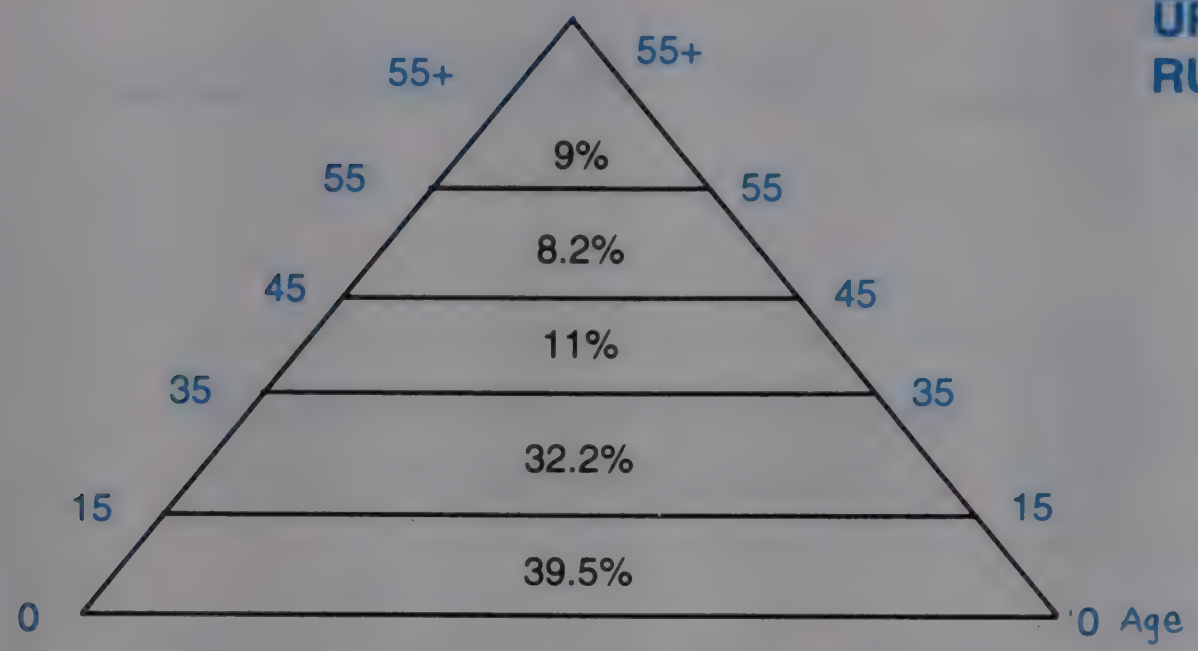
THE PROBLEM

- 20%-25% OF HIV INFECTIONS IN THE AGE RANGE OF 10-24
- YOUTH PERCEIVE THEMSELVES AS INVULNERABLE
- YOUTH TAKE RISKS
- YOUTH IN INDIA HEAR ABOUT SEX FROM PEERS AND PORN
- PERCEPTION OF SEXUALITY DIFFERS THROUGHOUT INDIA
- INCREASE IN DRUG USE ESPECIALLY INJECTING DRUG USE BY YOUTH IN THE COUNTRY.

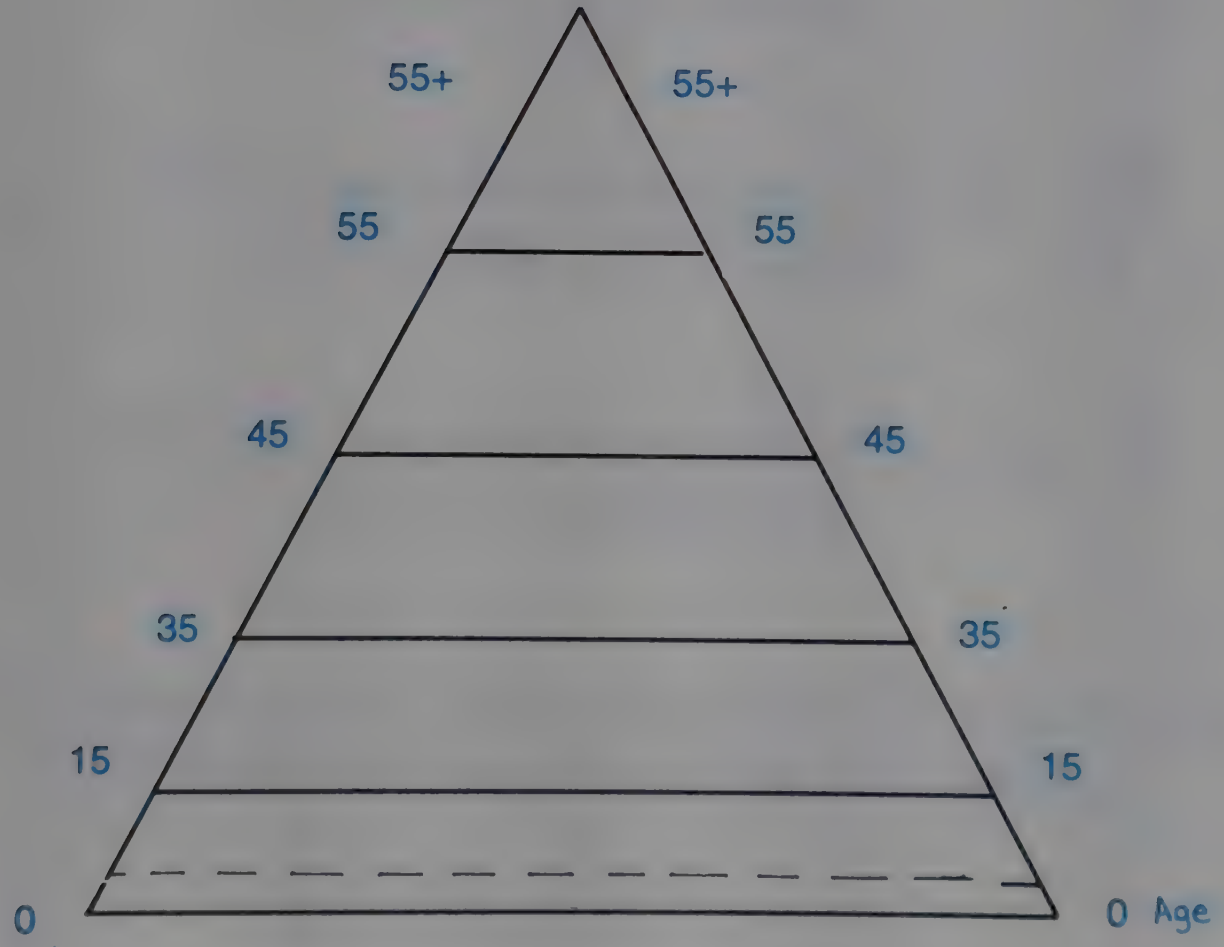
SLIDE 12

POPULATION PROJECTION

URBAN 26%
RURAL 74%



POPULATION : 1991
844 MILLION



POPULATION : 2001
1000 MILLION (ESTIMATED)

SLIDE 13

FACTORS WHICH LEAD YOUTH INTO HIGH RISK SITUATIONS :

- Socio-economic disadvantage and deprivation.
- Urban residence and exposure to an expensive modern style of life which is often beyond their means.
- Weakening of traditional value systems and social control due to migration or forced displacement and subsequent erosion of parental control.
- Exposure to role models and living standards that are in conflict with their traditional norms and values.
- Lack of adequate supervision and social control by parents, schools and other traditional agents of socialisation due to loss or disintegration of the family system.
- Reinforcement of high risk behaviours by newly acquired reference groups and sources of public information and education (international media).
- Economic need and the inevitability of high risk behaviour as a means of survival.

The above conditions are often associated with secondary factors such as lack of access to accurate information, unavailability of means for protection and prevention and general absence of appropriate role models and support services for prevention.

SLIDE 14

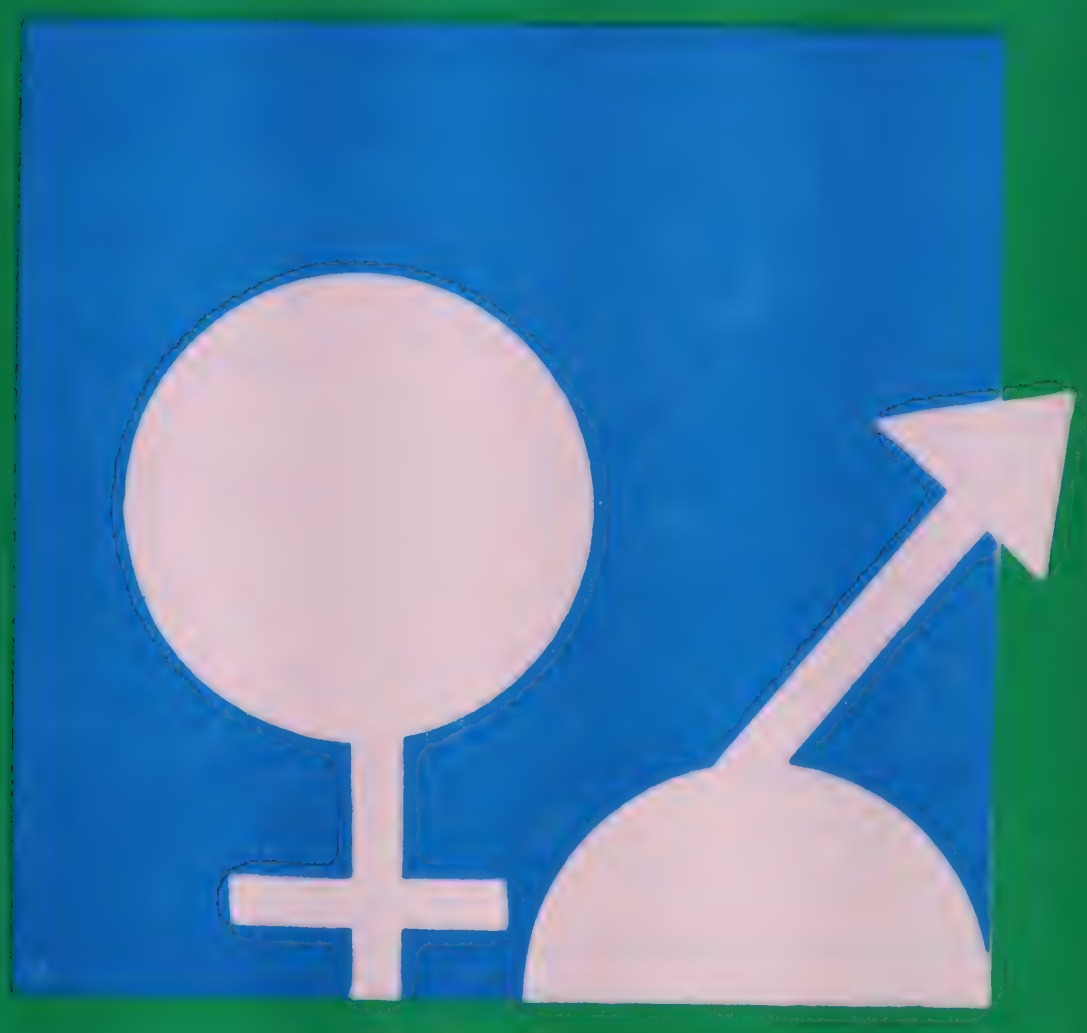
THREE MAJOR INTERVENTION STRATEGIES

1.
INFORMATION, EDUCATION AND COMMUNICATION

2.
CONTROL OF SEXUALLY TRANSMITTED DISEASES

3.
CONDOM PROGRAMMING

TRAINING MODULE II



HUMAN SEXUALITY

CHAPTER 4

TRAINING MODULE II

HUMAN SEXUALITY

Sub-Sections **Duration: 4 hours**

I. Concept Clarification

II. Sexuality : Misconceptions & Beliefs

III. Growing up Processes in Boys & Girls

IV. Sexually Transmitted Diseases

V. Responsible Sexual Behaviour

Learning Objectives

1. To understand the concept of human sexuality and develop feelings of respect towards one's own sexuality and that of others.

2. To know the male and female anatomy, with reference to sex organs, puberty and sexually transmitted diseases and reflect on the existing myths and misconceptions.

3. To realise the value of responsible decisions in matters of sex.

4. To be able to discuss freely matters pertaining to sex.

Note : This module is written on the assumption that the trainees are of both sexes. Even when the members belong to only one sex, please ensure that sexuality aspects of both sexes are dealt with.

Module :II

Subsection:1

Duration: 45 Minutes

HUMAN SEXUALITY : CONCEPT CLARIFICATION

Specific Objectives

1. To clarify to oneself major concepts related to sexuality.

2. To be able to personalise the notion of sexuality.

Material Needed

One chart paper and two felt pens each for 8 groups.

Group Size

20 - 40 participants

Method

1. The facilitator asks the trainees to recall all that they can, regarding their process of growing up. They are asked to discuss these memories in sub-groups of about 5 - 7 trainees each. If necessary, the participants may reflect on either their own growing up or growing up of other younger individuals at home, such as younger siblings. The participants may be encouraged to begin from the first time they noticed that they belong to one particular sex and early questions and issues that they wished to clarify, either from their parents, or from elder brothers and sisters.

   They should reflect on the early infatuations with people of same/opposite sex and the beginning of learning to appreciate individuals either of the same age or at times individuals of older age from opposite sex.

2. The discussion of each group is then shared in the main group. They are given 5 minutes for presentation.

3. The facilitator can then summarise session by emphasising the following :

(i) Helping them to understand that emotional and social changes are as important as physical changes in growing up and these changes differ depending on their upbringing and self image.

(ii) Offering a broad definition of human sexuality (see chart I). Emphasise that sexuality is a lifelong matter and that it is not just a physical affair; it includes how a person thinks, feels and acts, in relation to sexual matters, how one sees the world and how the world visualises men and women as human beings;

(iii) Pointing out that differences in sexuality relating to gender are more an outcome of socialisation rather than innate differences between men and women.

(iv) Clarifying that sexual thoughts and behaviour are a natural part of human existence. The frequency with which these thoughts come may vary and what stimulates sexual thoughts and behaviour could be different for different individuals.

(v) Finally, reminding the group that the precautions for the prevention of HIV relate mainly to sexual acts specifically intercourse and not to other expressions of sexuality. The emphasis therefore in the remaining part of these sessions will be on 'sex'.

(vi) Reproductive health.

Casual flings may be FUN but imagine the harm that may be done!

CHART - I

HUMAN SEXUALITY

Definition:

HUMAN SEXUALITY IS A FUNCTION OF YOUR WHOLE PERSONALITY

THAT IS LIFELONG, BEGINNING FROM BIRTH . IT INCLUDES -

1) **HOW YOU FEEL ABOUT YOURSELF AS A PERSON.**

2) **HOW YOU FEEL ABOUT BEING A MAN OR A WOMAN.**

3) **HOW YOU GET ALONG WITH MEMBERS OF EITHER GENDER.**

SEXUALITY ALSO INCLUDES GENITAL AND REPRODUCTIVE

HEALTH SUCH AS INTERCOURSE AND CHILD BEARING.

IT IS THE WAY YOU THINK, FEEL AND BEHAVE.

Module:II

Subsection: II

Duration : 45 Minutes

SEXUALITY : MISCONCEPTIONS AND BELIEFS

Specific Objectives

1. To be able to clarify misconceptions about sex and sexuality.

2. To understand how myths develop.

Material Needed

Index cards with one statement written on them with equal number of cards for each team. (Refer Resource Sheet attached herewith.)

Blackboard, chalk.

Group Size

As many members as needed.

Method

1. Tell the group that they are going to play a game that will help them to learn the truth about sexuality and sex-related information. Divide them into teams, with not more than 4 members in each team. State that each team will pick up one card turn-wise. The volunteer who picks up the card reads it aloud. Team members can take a short time to decide whether the statement is a myth or a fact. The volunteer should announce the decision of the team.

2. On receiving an answer to each statement the facilitator asks the other group their opinion. He/she then states the response. Allow a few minutes for discussion of each statement.

3. During the game if a group member's response is laughed at, remind the group that

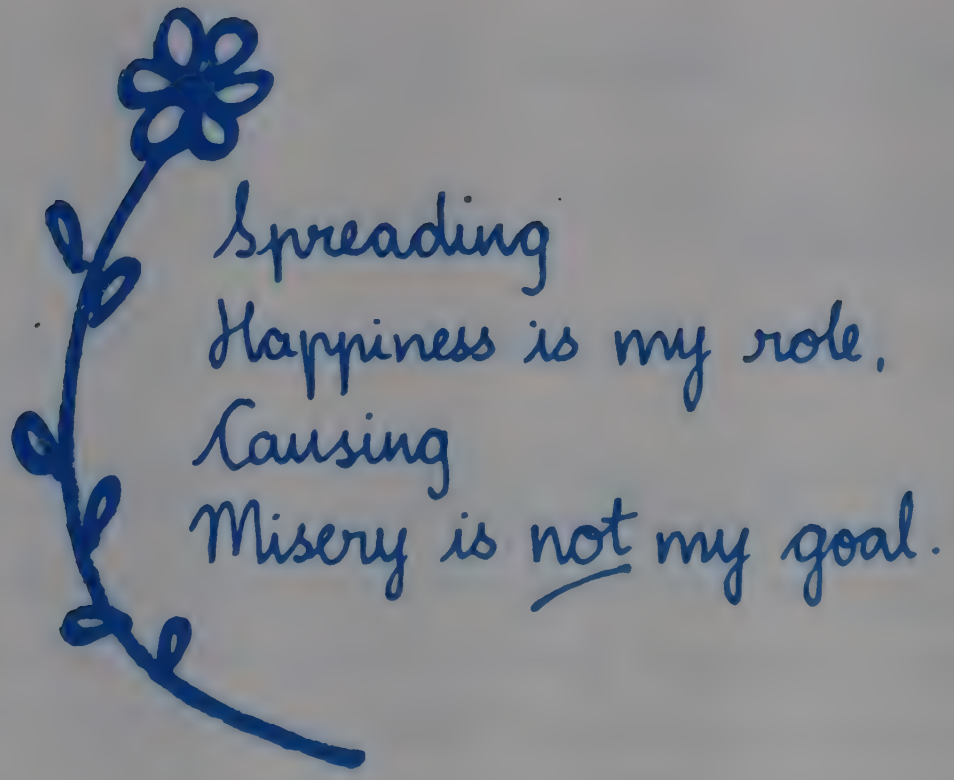
everyone has beliefs and we are here to learn. State this in a matter-of-fact way without anger or sarcasm.

4. Finally ask the trainees if they have additional questions on any belief. Reassure the group that most people have beliefs based on incorrect information but that open minded people are willing to admit that they are misinformed.

5. Probe why such myths develop and spread (viz. cultural aspect, lack of sources of correct information) and what can be done to eradicate them.

6. Also discuss the anxiety related to a particular belief and how it adversely affects one's attitude towards sexuality and sexual life, e.g. loss of semen and strength.

7. The facilitator while giving the explanation for statements should also corelate possibilities of HIV/AIDS, whenever possible.



RESOURCE SHEET ON BELIEFS

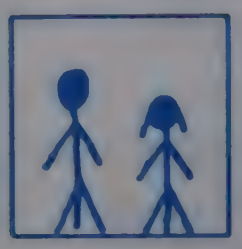
BELIEF (For Index Card)		EXPLANATION (for facilitator)
1. Once a girl has had her first period, she can become pregnant.	Fact	When a girl starts having menstrual periods, it means that her reproductive organs have begun working and that she can become pregnant. It does not mean, however, that her physical organs and body, and mental condition are necessarily prepared for the birth of a child.
2. Before a girl has had her first period, she can become pregnant.	Fact	Because a women's ovaries release an egg **before** the onset of her menstrual period, it is possible for a girl to get pregnant before her first period.
3. It is unhealthy for a girl to bathe or swim during her period.	Fallacy	There is no reason that a woman, should not indulge in a specific activity during her period, unless she has cramps or any such discomfort. She must maintain hygiene, in particular.
4. Abstinence is the only method of birth control that is 100% effective.	Fact	The only way to be absolutely sure of avoiding pregnancy is to avoid having sex.
5. Girls and boys can have sexually transmitted diseases without having any symptoms.	Fact	While some STDs may have quite recognizable symptoms, others may not. Gonorrhea, for example, typically displays no symptoms in women and often is undetectable in men. It is important to be examined by a doctor if you think you may have an STD.

6. A girl cannot get pregnant if she has sex only once or a few times.	Fallacy	A girl can get pregnant with a single intercourse including her first one.
7. A girl can get pregnant if she has sex during her period.	Fact	It is possible for a girl to get pregnant at any time during her menstrual cycle.
8. Once you've had gonorrhea and have been cured, you can't get it again.	Fallacy	A person can get gonorrhea as many times as he or she has sex with an infected person. It is important, therefore, that anyone who is treated for gonorrhea (or any other STDs, for that matter) make sure that his or her sexual partners are treated, as well.
9. Condoms help prevent the spread of sexually transmitted diseases.	Fact	Not only are condoms an effective method of birth control they are also effective in preventing the spread of many STDs.
10. The size of the penis is equivalent to masculinity or virility	Fallacy	The size of the penis either when it is flaccid (not erect) or when erect is no indication of a man's masculinity or sexual ability.
11. A girl can get pregnant even if a boy doesn't ejaculate or "come" inside her.	Fact	Even if a boy does not ejaculate inside a girl's vagina, it is still possible that pre-seminal fluids will contain sperms, therefore a girl can get pregnant.
12. Sexually transmitted diseases can be cured if the infected boy has sex with a virgin.	Fallacy	STDs require regular medical treatment. By having sex with a virgin or anyone else, one will only pass this infection
13. Menstruation is unclean.	Fallacy	Menstruation is related to the cycle of life. The uterus prepares itself for the growth of the fetus, if and when conception takes place. When conception does not occur, the inner layers of the uterus shed its preparation which results in menstruation.

14. The female determines the sex of a baby.	Fallacy	The male genetic material determines the gender of a baby on the basis of its genetic endowment. (xx Chromosome)
15. Nocturnal emissions make boys weak.	Fallacy	Loss of semen through a wet dream, masturbation, or sexual intercourse is a perfectly natural, harmless thing. It does not make one weak.
16. Masturbation is normal.	Fact	It is normal sexual activity practised by both sexes (male/females).
17. Homosexuality is abnormal	Fallacy	A homosexual is a person who is attracted to persons of the same sex rather than opposite sex and derives sexual pleasure from them. Both men and women can develop such attraction towards members of their own sex. Some of them pass through this stage at some time in their lives but a few may continue to feel this way for life. It should not be seen as abnormal, and is a matter of one's personal choice.
18. Circumcision increases the sexual power of the man.	Fallacy	Circumcision is a procedure by which the loose fold of the foreskin of penis is cut off. After the operation, intercourse, if it was painful for the male earlier, becomes painless, and it is easier to keep the penis clean. However, there is no change in the sexual pleasure or powers of the man.
19. A drop of semen is equal to 20 drops of blood. Hence the loss of semen weakens the body and should be avoided.	Fallacy	Semen has no relationship with blood and its loss causes no weakness to the body. Semen is meant to be released from the body.

Module II

Subsection III **Duration: 45 Minutes**



GROWING UP PROCESS IN BOYS & GIRLS

Specific Objectives

To understand the process of growing up from the reproductive and anatomical perspective.

Material Needed

Photocopies of the blank sheets of the sexuality facts (at least one set for each group). Transparencies of correct answers.

Size of Group

Divide the participants into groups of five or less.

Method

1) Ask the group to fill out the correct answers for the three sheets after discussing within the group. The participants will also discuss the various functions related to the individual parts. This process should take only fifteen minutes.

2) Ask one of the groups to come and present their findings on the anatomy drawings. After the presentation discuss what was correct or wrong in their findings with the participants and suggest changes/modifications etc.

3) Thereafter the facilitator would sum up the various points raised in the group and clarify any doubts that may come up. Use transparency of correct answers for this purpose. (make sure you block the correct answers for the female anatomy drawings while you do this.)

4) Repeat the same process with the female anatomy drawings.

With the help of slides, explain the male and female sex organs, in relation to the process of growing up. The main points that may be included are :

Sex Organs of Boys and related functions/processes : **These are**

a) **Penis** : The male organ for sexual intercourse.

b) **Scrotum** : The pouch located behind the penis which contains the testicles, provides protection to the testicles, controls temperature necessary for sperm production and survival.

c) **Testis** : Two round glands which descend into the scrotum following birth, produce and store sperms starting in puberty; produce the male sex hormone testosterone.

d) **Seminal vesicle** : A sac-like structure lying behind the bladder; secretes a thick milky fluid that forms part of the semen.

e) **Prostate gland** : A gland located in the male pelvis which secretes a thick milky fluid that forms part of the semen.

f) **Erection** : The process by which the penis fills with blood in response to thoughts, fantasies, temperature, touch or sexual stimulation and grows taut.

g) **Ejaculation** : The release of semen from the penis caused by sexual excitement is called ejaculation. This occurs in situations other than intercourse as well e.g. it may occur at night and is commonly called a 'wet dream'. This name however is a misnomer for nocturnal emission, as it does not occur only in dreams. The Hindi & Marathi word "Swapna dosh" is also a misnomer, as dosh indicates defect/fault. It is a natural and normal phenomenon. (During ejaculation, the urethra is closed to urination).

Secondary Sex characteristics :

The pace of the growing up process is not the same in all individuals, some may get their beard and hair on the chest at an early age; some may have a thick growth while in others it may be sparse. The height and voice changes are also not standard. The size of the penis also varies. One must accept one's growth process as individualistic and respect that of others. One must also take good care of one's personal hygiene so that it adds to one's urge to look good and feel good and be attractive to others. In boys, besides normal personal hygiene measures, during bath and after urination they must gently pull back the foreskin of the penis (for those who are not circumcised) and wash the penis with plenty of water. One must attend to dental hygiene as well as body odour by keeping clean and using deoderants and/or powders and wearing clean undergarments and clothes. This adds to ones attractiveness to the opposite sex, as well.

Sex organs of girls and related functions/processes :

1. With the help of slides, explain the following :

a) *Labia majora and labia minora* : Two sets of folds on either side of the vagina; provide protection to the clitoris and the urethral and vaginal openings.

b) *Clitoris* : A small structure located above the urethral opening at the point where the labia meet; the focal point of stimulation for the female.

c) *Vaginal opening* :Located between the urethral opening and the anus; usually covered by a thin membrane prior to first experience of intercourse; outlet for the menstrual flow.

d) *Pelvis* : The basin-shaped bone structure that provides support and protection to the internal reproductive organs.

e) *Vagina* : Passageway extending from the uterus to the outside of the body; canal through which a baby passes during delivery; passageway for the menstrual flow to the outside; place where intercourse occurs. Capable of expanding during intercourse and childbirth. Lubricates during sexual arousal; girls often experience vaginal lubrication and possibly orgasm during sleep.

f) *Cervix* : The mouth or opening into the uterus; protrudes into the uppermost part of the vagina.

g) *Hymen* : It is a fold of mucous membrane stretched across and partially closing internal orifice of the vagina. In India, much importance is attached to the hymen. The presence of the hymen is believed to be linked to one's virginity. This is however not true, as it can break not only by sexual intercourse, but also by participating in certain kinds of physical activities and even in accidents. In some cases it may not be there at all.

h) *Uterus* : A pear-shaped muscular organ located in the pelvic region; beginning at puberty, the lining sheds periodically (usually monthly) during menstruation; baby develops within it during pregnancy.

i) *Fallopian tubes* : Passageway for the egg from the ovary to the uterus; place where fertilization occurs.

j) *Ovaries* : Oval-shaped structures located in the female pelvic region; contain 300,000 to 500,000 egg cells at birth; produce female sex hormones, estrogen and progesterone; begin release of eggs at the time of puberty.

k) *Ovum or egg* : About the size of pinhead if not fertilized, dissolves and is absorbed. Usually one egg is released once a month; if more than one is released and they are fertilized, it may result in twins or multiple births.

l) *Ovulation* : During ovulation, an ovary releases a mature egg which then becomes available for fertilization; occurs approximately 14 days before a menstrual period begins, but is frequently irregular in young girls. The first ovulation may or may not coincide with the first menstrual period; a girl may begin to ovulate before, at the time, or some time after she first menstruates. Multiple ovulation may result in twin or multiple births.

m) *Fertilisation* : The union of an ovum with a sperm in the fallopian tube. Sperms are capable of fertilisation up to 7 days after intercourse.

Menstruation

Significance : It is the physical preparation for motherhood.

Function : Periodic shedding of the uterine lining which has formed in preparation for a fertilised egg.

Age of onset : Varies, from age 9-17 years.

Termination : Temporary-during pregnancy, after a long illness or a mental trauma.

Permanent : between the ages of 45-55 years.

Length of cycle : Varies; average is 28 days. Intervals may be irregular in young girls.

Duration of flow : Varies; average is 2-7 days. Amount of flow also varies. Some girls/women experience cramps caused by uterine contractions.

Hygiene : A daily bath is an absolute necessity but it may be necessary to bathe more frequently. Use sanitary protection which must be changed frequently.

Common misconceptions regarding Menstruation :

i) "Boys can tell when a girl is having her menstrual period." There is no way one could do this. There are no symptoms of menstruation, which one could tell by seeing a person.

ii) "Bathing causes menstrual cramps." This is again not true. On the other hand, it is extremely important to have a regular bath and maintain proper hygiene during this period.

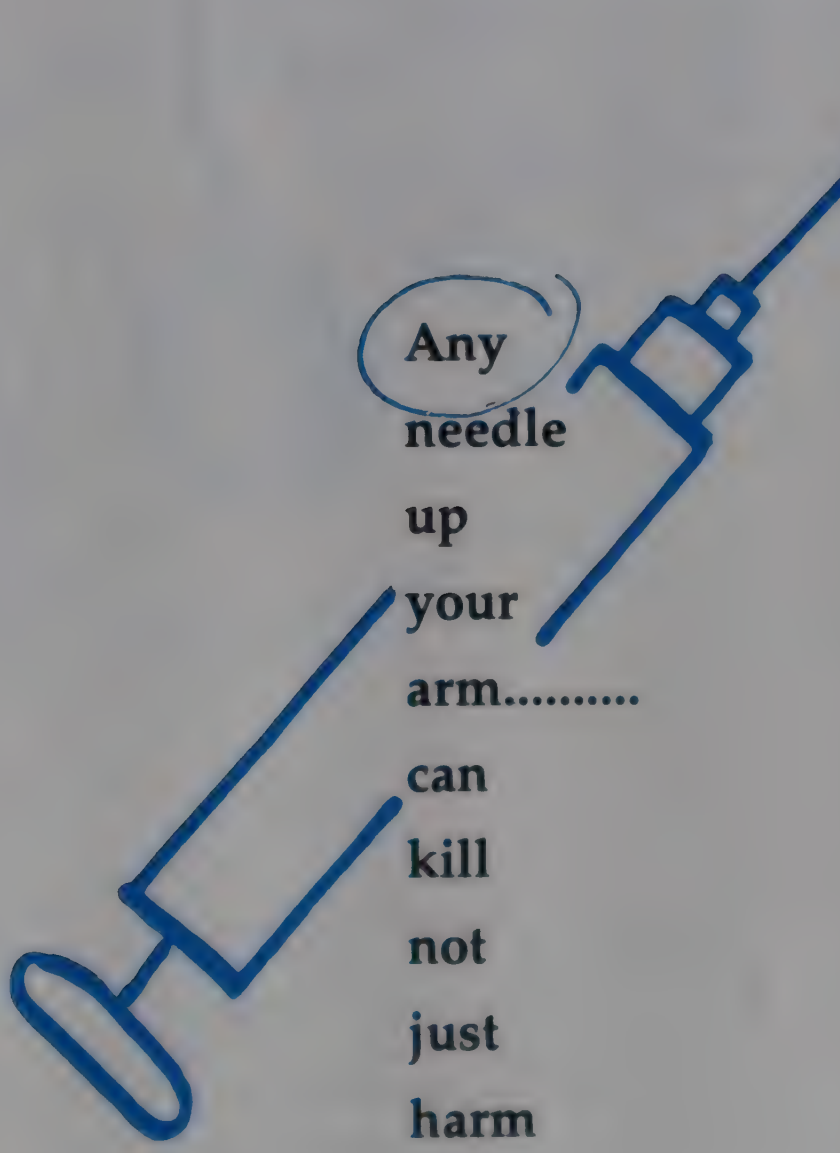
iii) "Bathing and washing one's hair is harmful while menstruating." There is absolutely no connection between the two.

iv) "Boys are more likely to get sexually transmitted disease(s) when they have intercourse at the time of partner's menstrual period." This is not true. However, the transmission of HIV virus is more assured in sex during menstruation, if either partner is infected.

2. Allow time for discussion to remove doubts and offer clarifications, if any.

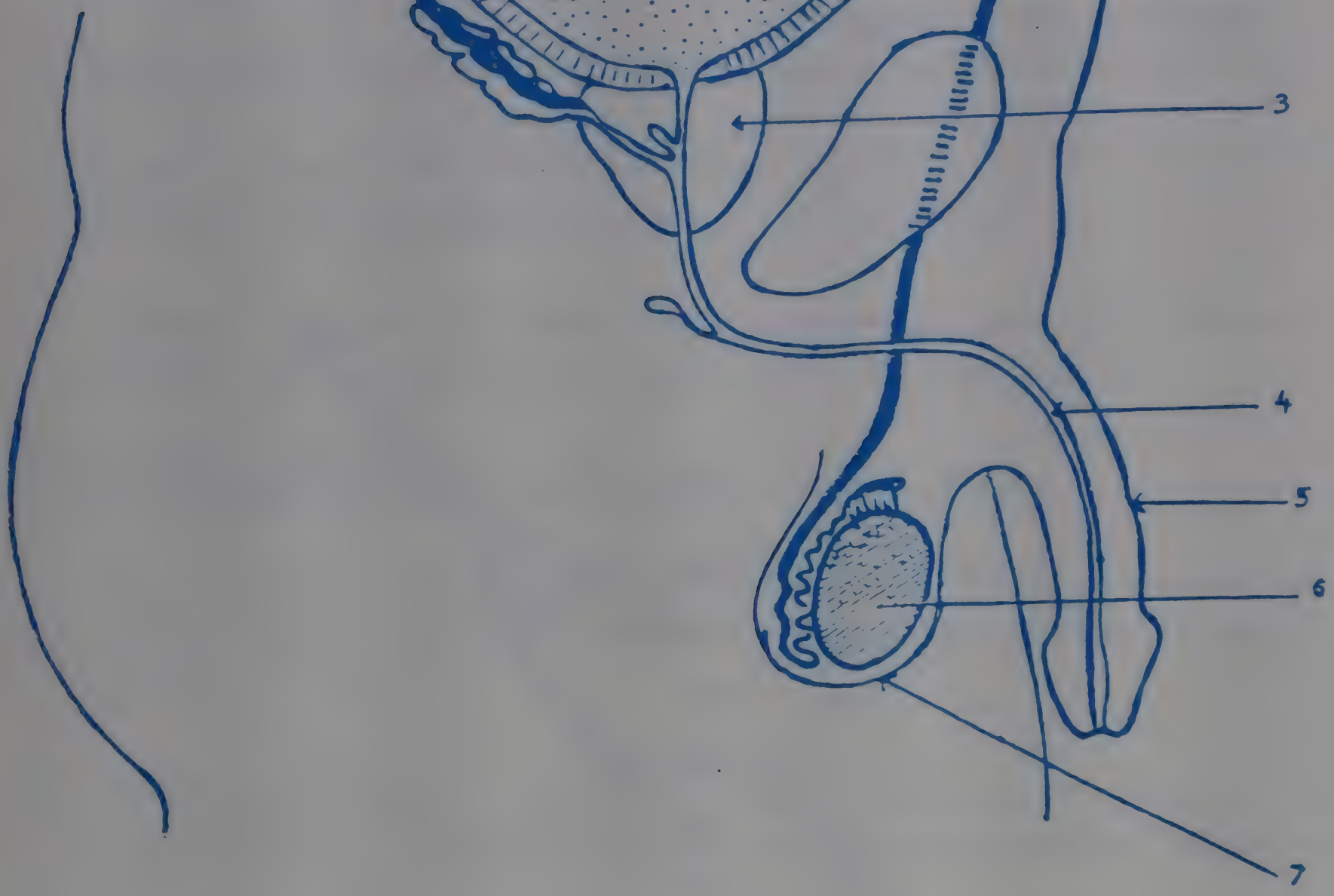
3. Use transparencies 1 to 3, and invite trainees to identify the parts given in the drawings.

4. Ask the group to list mental and emotional changes in puberty e.g. feeling of attraction towards the opposite sex, obsession for good looks, etc. Conclude by emphasizing the following: growing up is a natural process; it varies in different individuals, there is need for hygiene and prompt medical attention in case of any suspected symptoms of ill health;and that growing up is a holistic process physical, mental and social. Good health, positive thinking, healthy social relationships and pursuits of socially relevant and acceptable interests will ensure a happy life.



SEXUALITY FACTS

Anatomy Drawing (Male)



1. _____

2. _____

3. _____

4. _____

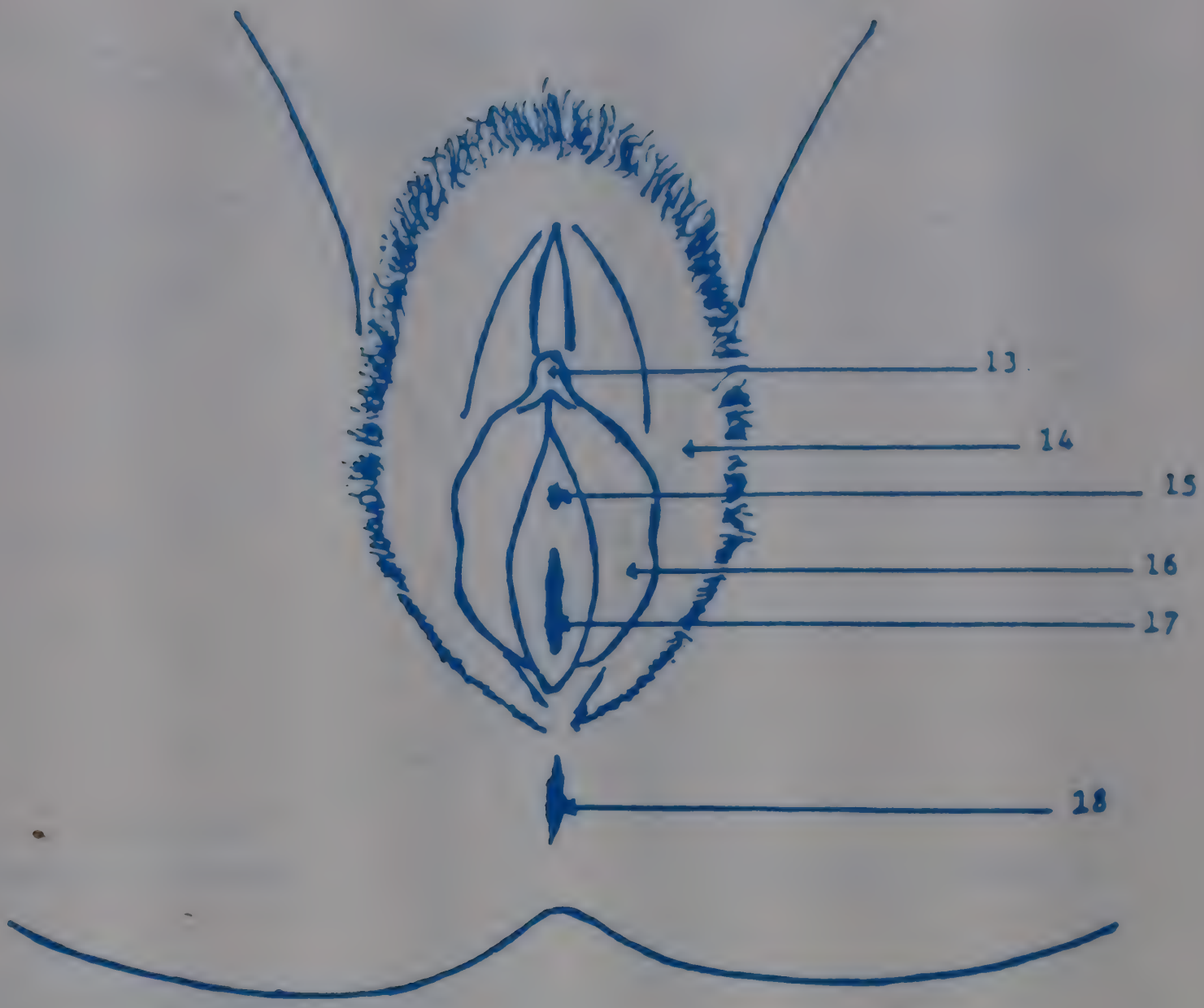
5. _____

6. _____

7. _____

SEXUALITY FACTS

Anatomy Drawing (Female - External)



13. _____

14. _____

15. _____

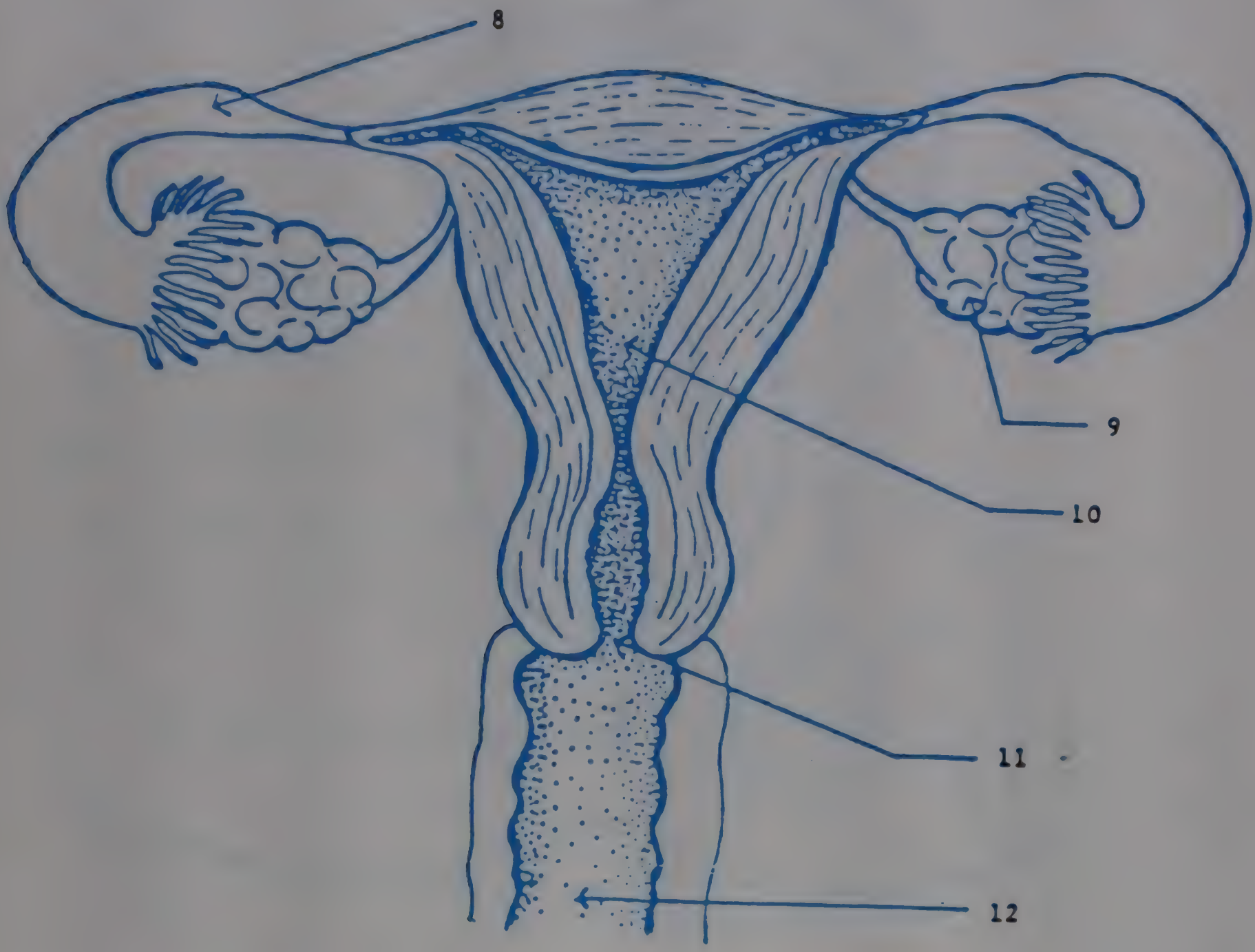
16. _____

17. _____

18. _____

SEXUALITY FACTS

Anatomy Drawing (Female - Internal)



8. _____

9. _____

10. _____

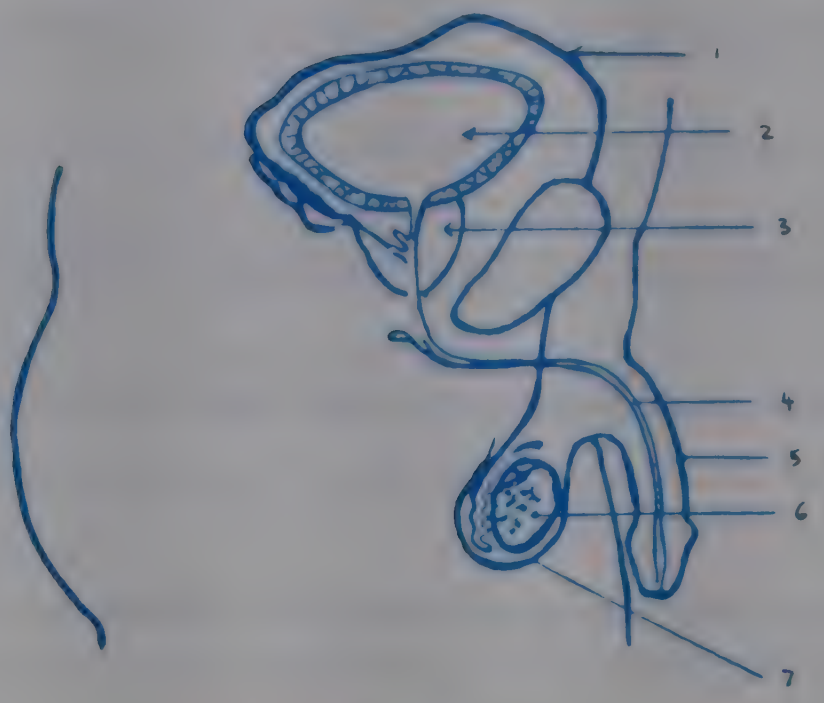
11. _____

12. _____

SEXUALITY FACTS

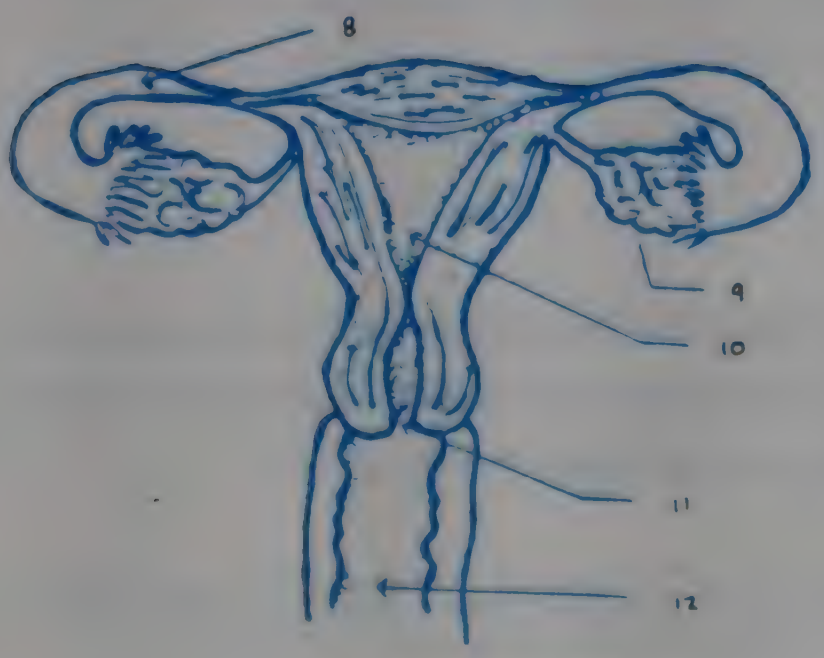
Anatomy Drawings - Correct Answers

Male



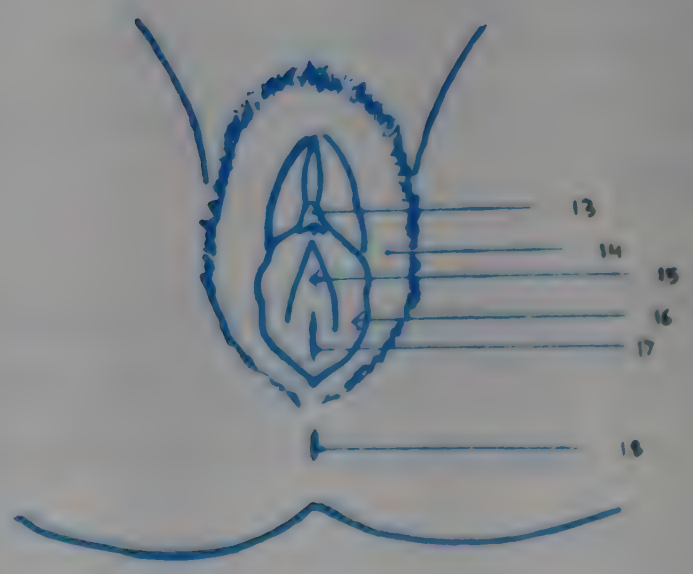
1. Vas deferens
2. Bladder
3. Prostate gland
4. Urethra
5. Penis
6. Testicle
7. Scrotum

Female — Internal



8. Fallopian tube
9. Ovary
10. Uterus (Womb)
11. Cervix
12. Vagina

Female — External



13. Clitoris
14. Labia majora outer lips
15. Urethra (opening)
16. Labia minora (inner lips)
17. Vagina (opening)
18. Anus (opening)

Module: II

Subsection : IV **Duration: 30 minutes**

SEXUALLY TRANSMITTED DISEASES (STDs)

Specific Objectives

1. To learn about STDs and their transmission and prevention.

2. To understand the value of prevention and treatment of STDs especially in the context of HIV.

3. To understand the importance of appropriate medical care for treatment of STDs.

Material Needed

Transparencies/Flip charts (text enclosed), blackboard and chalks, handouts on STDs (attached herewith)

Group Size

10-40 participants

Method

1. Ask the group if they have heard of STDs. Write the responses on the blackboard/flip charts. Then with the help of slide 1 explain that STDs are mostly sexually transmitted and some of the common ones are syphilis and gonorrhea.

2. Ask the group what is the relationship between STDs and HIV? Explain using slide 2.

3. Ask the group if they know of some symptoms of STDs. Write down the responses and explain with the help of slide 3 some of the symptoms. Take care to point out that some STDs are without any symptoms especially in women. The chances of acquiring the HIV

infection becomes fourfold when the person has any STD. The presence of the STD facilitates the transmission of HIV.

4. Ask the group if they know of methods of prevention of STDs and clinics where they can get treatment for it. Write down the responses and with the help of Slide 4 explain that reduction in number of partners and proper use of condoms can prevent the transmission of STDs. Treatment should be sought from a qualified doctor.

5. Ask the group if treatment should be only given to the male partner or the female partner. With the help of slide 5 explain that treatment should be given to all sexual partners, even though only one may have symptoms or come for medical advice. Any one who suspects that he/she has an STD should go for check up.

6. Ask the group if they know about the rates of STDs in the country. Explain the situation with the help of slide 6.

7. Ask the group to mention some consequences of having STDs. Explain with the help of slide 7.

8. Summarize the discussion using slide 8 and saying that most STDs are curable and all STDs are preventable including HIV/AIDS. There are various social consequences as a result of having an STD which should not act as a barrier while seeking treatment.

Notes to the Facilitator

1. The facilitator introduces the subject by stating that there are some diseases that are spread by sexual contact. They are called Sexually Transmitted Diseases (STDs). The vagina, penis, rectum and mouth provide the ideal environment for the STDs germs to invade the body.

   Most STDs are painful and they can cause a lot of damage to the body resulting in illness, disability and even death. Most STDs in women can infect babies in the womb or during delivery, causing severe handicaps and even deaths.

2. In India, there is a very high incidence of STDs, primarily because contrary to popular belief many people in the country have sex with multiple partners. In addition to this there is lack of knowledge of STDs, inadequate health facilities, inadequate utilisation of health facilities due to stigma associated with STDs and urbanisation which at times, compels the person to leave his/her spouse and family in the villages. Limited condom use

and lack of personal hygiene are other factors.

3. HIV infection/AIDS is also a kind of sexually transmitted disease, the significant difference being that while most of the other STDs can be cured, ***HIV/AIDS is incurable.*** The incidence of HIV/AIDS is found to be directly co-related to the incidence of other sexually transmitted diseases, so people at low risk of STDs are also at low risk of HIV. For this reason too, it is important to concentrate on the prevention and treatment of STDs. The life style which prevents STDs will also prevent HIV.

4. Prevention of STDs infection :

Abstinence from all sexual activity is the most effective prevention. However, most people do not choose a lifetime abstinence. The risk of acquiring an STD, including HIV is virtually absent when one **has** sexual intercourse with a mutually faithful monogamous uninfected partner. In all other situations condoms should be used for protection against infections. Personal hygiene (washing of genitals after intercourse) might also contribute to prevention of infection, but by itself this is less effective than condom use.

5. Signs and Symptoms of STDs :

All STDs will not have signs and symptoms and the same STD may seem different in different people. It is extremely important to note that many women and some men have an STD without sign or symptom. The following signs could indicate presence of STD in a sexually active person :

Women : An unusual discharge or smell from vagina.

Pain in the pelvic area between the navel and sex organs.

Burning or itching around the vagina.

Bleeding from the vagina which is not the menstrual flow.

Pain inside the vagina when having sex.

In both men & women : Sores, bumps, blisters near the sex organs or mouth. Burning and pain when urinating or the bowel movement.

Swelling in the groin - the area around the sex organ.

Men : A drip or discharge from the penis.

Some symptoms of STDs can also be symptoms of non-sexually transmitted diseases. It is also possible to have more than one disease at a time. The best response to a suspected STD would be to abstain from sexual activity and seek medical attention. Sexual activity should be resumed only when infection is cured.

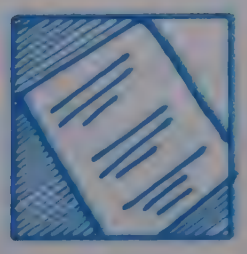
6. Emphasise that all STDs except AIDS are curable and all of them including AIDS are preventable. Prompt attention from licensed medical practitioners and regularity of treatment for STDs is a must to prevent complications.

7. Allow the group to ask questions. Give the Handout on the subject to trainees, and ask them to read and discuss in small groups, putting forward their questions.

8. Conclude by emphasising the importance of caring for one's health through responsible sexual behaviour, appropriate prevention through condom use and personal hygiene. Also answer the questions noted.

OUR
careless lifestyles
MAY
cost many
THEIR
lives !

HANDOUT

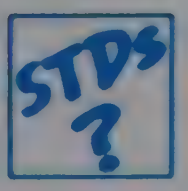


SEXUALLY TRANSMITTED DISEASES

Why do we need to know about sexually transmitted diseases?

As a youth leader, you will need to discuss subjects relating to AIDS. AIDS is only one of the sexually transmitted diseases (STDs) and knowledge about the others will help you to answer their questions. If the youth members are already sexually active, it will help them to protect themselves from infection. If they are not sexually active, the information will provide a good basis for their understanding of AIDS.

What are sexually transmitted diseases?



STDs are those diseases which are transferred via the mucous membranes and secretions of the sexual organs, throat and rectum. Most STDs are easy to treat. If they are detected and treated early, they do not cause serious problems. If they are not detected and treated early, the infection may spread and cause complications such as sterility. They are relatively easy to contract, and so it is important to know what they are, what they look like and what you need to do to get them treated.

The following points provide basic information you need to know about STDs. The information is followed by questions to think about before preparing to discuss the subject. The most important thing to remember is that if you intend to have sexual intercourse, condoms are the best way of protecting yourself against STDs. Boys should make sure that they have a condom with them and that they know how to use it if they intend to have sex.
Girls should insist that their sexual partners should use condoms **prior to and during intercourse.**

How do I know if I have a sexually transmitted disease?

STDs often have very few symptoms. You may be infected for some time and not know it. The danger is that you can spread the disease to others without realizing it. The following describes some common STDs and how they are treated.

1. Gonorrhoea

Symptoms occur 3-5 days after infection. In men, it causes a yellow/green discharge and pain during urination. Women may also have a discharge. Both women and men may have no symptoms at all.

Treatment: Antibiotics. Both partners must take the treatment and not have sexual intercourse until the treatment is finished.

Risks: If the infection is not detected and treated, then it will spread and may cause sterility in both males and females. There are some strains of gonorrhoea that are resistant to certain antibiotics, so it is important to be treated by a qualified health worker/doctor to ensure proper treatment.

2. Chlamydia

Caused by a bacteria. Often there are no symptoms. The infection may lie dormant for some time and then start to cause problems. The symptoms include a discharge or burning sensation when urinating. It may occur together with gonorrhoea.

Treatment : Antibiotics. It is very important that both partners are treated and that they avoid sexual intercourse until they have finished the treatment.

Risks: If Chlamydia is not treated, the infection may spread causing inflammation in the womb and sterility. It is a very common infection.

3. Syphilis

The first sign of infection is a small painless ulcer (cancre) at the site of infection - usually the sexual organs or the mouth - which appears 9 to 90 days after infection. This disappears in a few days and may not be detected. The infection lies dormant in the body for some time. Later a red rash may appear all over the body. This also can pass undetected.

Treatment : Antibiotics. Both partners need to be treated and they must not have sexual intercourse until the treatment is finished. If the small ulcer is not detectable, a blood test may be taken to detect whether infection has taken place.

Risks : f syphilis is left untreated it can cause major problems in later life. Heart disease is not

uncommon and in the terminal stages. Dementia is caused by infection in the brain. Women may pass on syphilis to their unborn child and this causes congenital abnormalities. Treatment can take place at any time once syphilis has been detected, but it is more successful in curing the disease and treatment is shorter, if detected early.

4. Chancroid

This infection causes small, usually painful ulcers on or around the genital organs. The ulcers tend to grow in size, and will not heal spontaneously.

Treatement : Antibiotics. Both partners need to be treated and they must not have sexual intercourse until they have finished the treatment and are cured.

5. Herpes

Caused by a virus. Herpes lives in the nerve root endings and once infected a person is infected for life. The first attack after infection is often the most painful. Small blisters occur around the site of infection - the mouth or the genitals - about 2-20 days after infection. The blisters may be accompanied by a high fever, general aches and pains and swollen glands. The blisters burst after about 2-4 days and eventually heal. Attacks occur about 3-4 times a year for many years but gradually decrease in intensity.

Treatment : There is no cure for herpes. The symptoms can be reduced by bathing the blisters in warm salty water and by taking painkillers. It is important to avoid sexual intercourse until the blisters have completely disappeared. To avoid spreading the infection, the sufferers should make sure they keep their own towel and avoid contact with their eyes without first washing their hands.

Risks : Pregnant women can pass the infection on to their baby. Herpes may infect the brain and cause serious damage to the new born.

6. Trichomoniasis

Women complain of a smelly discharge, itching and soreness. Men usually have no symptoms at all. Symptoms start 2-3 days after infection.

Treatment : Both partners need to be treated. No sexual intercourse should take place until the treatment has finished.

7. Candidiasis

This is an infection of the vagina, caused by a fungus. It causes a whitish discharge, and itching in the vagina. Candida infection does not need to be sexually transmitted and can occur spontaneously.

Treatment : Vaginal tablets with an anti-fungal drug.

8. Condyloma

A virus that causes warts which appear on or around the sexual organs. These flesh coloured bumps can be very difficult to identify, especially if they appear in the birth canal of a woman. They usually appear 3-9 months after infection. This long incubation period means it is difficult to find out where they came from and that they can be passed on to others.

Treatment : The warts are painted with a solution called podophyllin. The solution must be washed off after 4 hours to avoid irritation. No sexual intercourse should take place until the warts have completely disappeared.

Both partners need to be checked to see if they have any warts.

Risks : Women who have come in contact with the Condyloma virus should have their wombs checked regularly for the first stage of cancer. The Condyloma virus is very common.

It is important that sexually transmitted diseases are adequately treated. If not, they can become chronic and be the cause of serious complications. For adequate and effective treatment it is necessary to go to a qualified doctor. Self-treatment or treatment by quacks are not sufficient.

SLIDE 1

SEXUALLY TRANSMITTED DISEASES

STDs ARE THOSE DISEASES THAT ARE MOSTLY TRANSMITTED THROUGH SEXUAL INTERCOURSE

There are many STDs,
other than Gonorrhoea and Syphilis

SLIDE 2

STDs AND HIV INFECTION

The relationship between STDs, such as for instance syphilis, herpes, gonorrhoea and chancroid, and HIV infection is as follows :

- The **same risk behaviours** that predispose for STDs also predispose for HIV infection (that is unprotected sex with multiple partners)

- The presence of STDs facilitates the **transmission and acquisition of HIV infection up to 10 fold** (acquisition by providing an entry point for the virus and transmission by providing an exit point, as well as increased exposure through white blood cells [pus] containing HIV). This means up to a 10 times increase risk of transmission if one of the partners is infected with HIV and one of the two has an STD - for instance from 1 in 1000 to 1 in 100; or 1 in 100 to 1 in 10.

This means that anyone who has (had) an STD is also at risk for HIV infection, both through the predisposing behaviour, as well as through the increased risk associated with STD themselves.

SLIDE 3

SYMPTOMS OF STD CAN BE :

- Discharge from penis or vagina
- Ulcers on genitals
- Swelling in groin
- Abdominal pain

BUT MANY STDs, ESPECIALLY IN WOMEN, ARE WITHOUT SYMPTOMS

STDs FACILITATE THE TRANSMISSION OF HIV INFECTION

SLIDE 4

SEXUALLY TRANSMITTED DISEASES

- **PREVENTION :**
  - * **THROUGH REDUCTION OF NUMBER OF SEXUAL PARTNERS**
  - * **USE OF CONDOMS**

- **CURE :**
  - * **FROM A QUALIFIED DOCTOR**

Treatment from quacks, or self-medication is insufficient and might lead to chronic infections

SLIDE 5

- **ANYBODY WHO SUSPECTS HE/SHE MIGHT HAVE AN STD SHOULD GO FOR A MEDICAL EXAMINATION AND GET TREATMENT**

Treatment should also be given to the sexual partner

SLIDE 6

STDs IN INDIA

Based on literature review and STD baseline surveys in various population groups:

- **STDs are common in urban and rural areas**
- **STDs are most common in the age group between 19-35 years**
- **The total number of new STD infection in the country is estimated at 40 million per year.**

SLIDE 7

- **STD, IF NOT TREATED PROPERLY, MIGHT LEAD TO :**

  - **Infertility (male or female)**
  - **Pregnancy wastage**
  - **Infections of newborns**
  - **HIV infection/AIDS**
  - **Cancers**
  - **Death**

SLIDE 8

STDs AND HIV CONTROL

Preventive measures for sexually transmitted HIV infection are the same as for STDs reduction in number of sexual partners (preferable one monogamous partner for life) and/or consistent condom use.

Additionally, early diagnosis and treatment of STDs will reduce the risk of HIV transmission and so reduce the spread of the epidemic.

Module: II

Subsection : V **Duration: 1 hour**

RESPONSIBLE SEXUAL BEHAVIOUR

Specific Objective

1. To appreciate the value of responsible sexual behaviour.

2. To clarify the doubts in relation to practice of responsible sexual behaviour.

Material Needed

Role play scenerio cards (content attached herewith).

Group Size

25-30 members

Method

1. Divide the group into small sub-groups of 5 members each. Each sub-group is given one role play scenario card. They will read the card and plan out the roles for 5 minutes in the sub-group in a way to show responsible sexual behaviour. They will then present this to the larger group.

   If there is time, then within the group, other volunteers or the same pair of volunteers may re-enact the role play.

2. Get the group to list factors that can promote responsible sexual behaviour in an individual.

3. Emphasise :

   a) Interaction between sexes is normal and healthy.
   b) Sex is beautiful but needs to be handled with maturity due to the consequences

- physical, emotional and health related. One can wait till one is older to handle sex for this reason.

c) Physical attraction between sexes though natural and normal cannot be the sole basis for a lifelong relationship.

d) Challenges from others about our ability to perform sexually are signs of immaturity. Our ability to be sexually active is not a sign of true mature adulthood but being able to wait is a definite sign of maturity.

4. Reinforce the importance of using the knowledge of human sexuality for responsible sexual behaviour. Physical attraction alone cannot be the basis for a sexually active relationship. It must be accompanied by TRUST and RESPECT.

To know - the likes and dislikes of the other partner. Knowledge brings compassion and understanding.

Responsibility- consciousness of one's behaviour and its effect on the other person and being able to respond to the socially acceptable and justifiable needs of the other.

Understanding - being able to place oneself in the shoes of the other and being sensitive to his/her needs and feelings.

Selflessness - willingness to work for and give oneself fully to each other.

Trust - Entrusting oneself to the other, having confidence in the strength and understanding of his/her love.

Besides these mutual commitments and responsiblities, a relationship requires - RESPECT - i.e. giving due concern to one's partner's rights and personality.

Role Play Scenerio Cards

1. Gautam is a boy studying in the first year of college. One day while he is waiting at the bus stop, a young attractive girl happens to ask him about the bus route of a particular place. Gautam instantly likes her and senses that she likes him. He feels he is in love with her and would like to marry her. The following day he meets her again at the bus stop, and decides that he will ask her to go to a film with him. Role play for 5 minutes.

2. Suguna and Sandeep are engaged and will be getting married after six months. They have been meeting regularly. Sandeep desires to have sexual intercourse, and tries to persuade Suguna to agree. Role play for 5 minutes.

3. Rashida is a second year student in college. Shivraj likes her. Though he knows her only from a distance, he discusses his liking for Rashida with a friend and insists that he tell Rashida of Shivraj's liking. Role play for 5 minutes.

4. Mukesh challenges his friend Gopalan to visit a prostitute to prove his masculinity. Role play the discussion that could follow, for 5 to 10 minutes.

5. Roshani is a first year student, in a coeducational college. She has been educated in a girls' school throughout. She feels at a loss in the college and wants to make friends with boys. She does not know how to achieve this, so she gives in to all the requests of her boy friends to be "popular". One day a boy asks her to have sex with him. Role play for 5 minutes.

6. Farooq persuades his girl friend into having sexual relations with him. Next day in a spirit of bravado, he describes the whole experience to his friends. Role play the discussion that could follow, for 5 to 7 minutes.

7. A group of boys and girls in a college, who have known each other for 3 years, are planning a "party". They intend to show a blue film and have a "free for all sex party"after dinner. As they are finalising the plans, Anil an N.S.S. youth leader walks into the room and tries to explain the moral, social and physical hazards of such sexual orgies. Role play the scene (with discussions) for 10 minutes.

TRAINING MODULE III

PSYCHO-SOCIAL IMPACT OF HIV/AIDS

CHAPTER 5

TRAINING MODULE III

PSYCHO-SOCIAL IMPACT OF HIV/AIDS

Duration: 5 hours 30 minutes
(30 minutes for Video film)

Subsection

I. AIDS and You: Values and Attitudes Clarification

II. Wildfire Game

III. Impact of HIV/AIDS

IV. Counselling and Referral Skills

Learning Objectives

1. To explore one's own feelings and attitudes towards HIV and AIDS related issues.

2. To understand how prejudice affects attitudes towards HIV/AIDS, and that there are limitec resources in relation to prevention, control and care.

3. To develop sensitivity to the issue and impact of HIV/AIDS.

4. To develop some sensitivity towards supports and services needed to reduce the impact of HIV/AIDS.

5 To imbibe rudimentary skills in counselling and referral on issues related to HIV/AIDS.

Messages to be Conveyed

1. HIV/AIDS causes strong prejudices and feelings that are not always open to rational thinking.

2. Prejudice affects how we look at people with HIV/AIDS and how we care for them.

3. HIV/AIDS has a multiple, crippling impact on the persons affected and their loved ones.

4. HIV/AIDS - affected persons need social support and services.

5. Counselling is our responsibility but it is a skill to be learnt and professional help may be seen as an option.

Module : III

Subsection : I **Duration : 1 hour 15 minutes**

AIDS AND YOU: VALUES AND ATTITUDES CLARIFICATION

HIV and AIDS are more than medical problems. Due to their association with sexuality, illness and death, they arouse strong feelings and relate to our values. In order to communicate on HIV/AIDS, we need to clarify our own values and attitudes on issues related to AIDS and help those with whom we communicate in order to understand their values and attitudes related to the same.

Activity: Exercise on Value Clarification or Forced Choice

Objective

To explore one's own values and attitudes related to AIDS.

Material Needed/Arrangements

Large room, five large pieces of white chart paper with one of the following written on it :

1. Strongly Agree
2. Agree
3. Strongly Disagree
4. Disagree
5. Not Sure/Confused

Method

a. Stick the first four pieces on four corners of the room and the 'confused' in the centre.

b. Ask participants to stand together in the middle of the room.

c. Announce that you will read out some statements. After you read one statement, the participants should immediately go to the piece of chart paper which best describes their response to it.

d. Emphasise the importance of responding to first reactions and acting accordingly.

Some controversial statements

1. Compulsory testing is the only way to control the spread of HIV.
2. Those infected with HIV have only themselves to blame.
3. Condoms should be freely available to all, regardless of age.
4. If unmarried persons come to know that they are HIV+, they should not get married.
5. Prostitutes, drug users and homosexuals are responsible for the spread of AIDS.
6. Injecting drug users should be provided clean needles on request.
7. People who have HIV/AIDS should be put in isolation.
8. There is nothing abnormal about having sexual relations with persons of one's own sex.
9. Safer sex should be taught to all young people in universities and colleges/schools.
10. People with HIV/AIDS must be punished if they do not inform others that they are infected.
11. Prostitution should be banned to prevent the spread of HIV/AIDS.
12. People with HIV/AIDS should not have children.

e. When they have responded to each statement as directed, they should find another person, standing at the **same** piece of paper and each should take 1-2 minutes to explain why he/she is standing there.

Note: They should not argue/discuss, but listen to the other's views, even if it is different from their own.

f. Participants should now 'cross the floor' and move to someone else in a different position and repeat the procedure for 1-2 minutes. Both should get an equal chance.

g. Participants should now move to the position that expresses their feelings **now.**

Points to be considered

a. The facilitator should move around but not intervene except when participants break the ground rules.

b. At the end of all statements, the following issues/ questions can be taken up for discussion:

- How did it feel to think about these statements?
- What kind of things did you think about when you were choosing a side?
- How much does peer pressure affect your values and their expression?
- Was it easy to change your stand? If you did so, what made you do that?
- How did it feel setting forth your views before the other participants, especially when you were in the minority?
- Before this exercise how often did you think about the values behind these statements?
- How did it feel to listen without being able to argue/discuss?

Points to be emphasised in the discussion

1. ***The faulty logic and prejudgemental attitudes behind demands for testing*** : Advocates of testing believe that the test will identify people who are likely to transmit HIV and will then enable society in some ways to prevent them from doing so. This argument is flawed.

The virus can exist in the body for a period any time between a few weeks upto 3 months (or even

longer) before antibodies are detected. This means that it is possible for someone to have the virus and yet have a 'negative' test result. If the test result for HIV is negative in a person, he or she is often advised to repeat the test after three months. If the person is infected, antibodies will have developed by that time. During this interim period, care must be taken not to participate in any activity which can transmit infection. Even if accuracy of the test is assumed to be high there would be a large number of people with either false negative or false positive test results. Hence, testing is useless for purposes of disease control.

Underlying this demand is essentially the prejudice about groups that are seen at risk, eg. sex workers, homosexuals, injecting drug users etc. The demand may thus arise from an uninformed fear and a desire to punish groups seen as 'responsible' for AIDS. Besides, taking a test demands a decision which is complex as it assumes a careful consideration of the consequences of a positive result. A positive result implies major changes in one's relationships with people, possible difficulties in finding or retaining employment, accommodation, etc. and often distress and pain at the individual level. Preparation for these consequences is essential before going in for a test.

In India, such tests are not available everywhere and counselling facilities of a uniform standard are not available in all parts of the country. Availability of testing needs to be backed by a strong counselling and support services network. In its absence, testing will only identify the infected but not help them to cope with HIV and live positively.

2. ***The trend towards scape-goating:*** Some groups in society are seen as 'inviting' AIDS due to their behaviour, e.g. sex with a partner of the same gender, prostitution, injecting drug etc. It is also true that people with AIDS are divided into 'innocent victims' and the 'guilty'. Babies with HIV infection, hemophiliacs, those infected with untreated blood, spouses of the HIV+ are seen as "innocent", deserving sympathy while the "guilty" viz. prostitutes, homosexuals, injecting drug users are seen as deserving to die. This tendency to isolate some for responsibility, leads to a chain of blame, anger and resentment, creates rifts between people, and does not contribute positively to the control of AIDS.

It is important to emphasise that AIDS is everybody's problem; that alternative life-styles, e.g. homosexuality, prostitution need to be understood; that certain life-styles are not really a matter of choice (e.g. prostitution) even if they seem to be. They are neither easy to alter nor do the persons adopting them, always want to alter them. Preventive behaviour for all is the most effective way to control HIV/AIDS rather than expecting **some** to give up a life-style or alter their behaviour. Society can, however, make it easier for some to adopt safer behaviour by specific

steps, eg. providing condoms, safe needles, alternative occupations, detoxification services, counselling and rehabilitation services, etc.

3. ***Understanding homosexuality:*** 'Gay' men or men who have sex with men are often seen as perverted and abnormal. In fact, attraction to the same sex is itself seen as immoral and unnatural. It must be emphasised that though different from the majority of people in society, homosexuality is not as uncommon as believed and has been around for centuries. Such individuals are often victimised by society because homosexuality is seen as a moral aberration rather than a matter of psychological and social identity and choice. The recognition of the existence and validity of homosexual relationships, helps in a non-judgemental attitude that contributes to being a person who accepts that people can be different and that all persons are equal and deserve respect. It is important to **accept** everybody even if we do not always **approve** of their behaviour.

4. ***The hesitation about condom availability and the spread of knowledge about the use:*** There are strong taboos - religious, cultural and social - that prevent the free availability of condoms, especially for young people. It is feared that availability of condoms will encourage sexual experimentation by the young. It needs to be emphasised that sexual experimentation occurs at this age in any case and often with erroneous and misconceived ideas that place youth at risk of STDs and AIDS; it is of importance to give correct information; it is important to transmit appropriate values about responsible sex; non-availability of condoms may place people at risk of exposure to AIDS; prevention can be made easier if placed in the hands of the people themselves, i.e. condoms are made accessible. This does not mean that one is encouraging young people to have sex.

Yet another barrier is condom education, viz. how to use condoms. The importance of condom use education needs to be seen vis-a-vis the possibility that lack of knowledge of proper use is likely to lead to breakage, spillage and thus, exposure to infection. Since such education is not being provided even in the family planning programme, its introduction will be useful. Besides, the interest of youth in AIDS education will be aroused as their curiosity will be satisfied.

5. ***The rights of the HIV/AIDS affected person:*** Society is often conscious of its rights to protect the uninfected against infection from HIV/AIDS. This is why there are repeated demands for isolation of people who have HIV/AIDS, and for informing their near and dear ones as well as acquaintances and colleagues of their HIV/AIDS status. Several counter-arguments can be offered.

- Isolation increases the visibility of the person.

- Isolation is stigmatising eg. leprosy.

- Prevention of transmission of infection does not necessitate physical isolation but preventive behaviour e.g. use of condoms. Such behaviour can occur when the person is part of society.

- Merely informing those in the social network may lead to rejection, social isolation and discrimination; counselling and seeking support however, may lead to a different outcome. The individual must be given the right to decide **whether,** he/she wants to inform, who he/she wants to inform, when and how he/she wishes to inform, etc. Persons with HIV/AIDS can be counselled in this area but informing against their wishes or without their consent is unethical and may have negative results. As this information is likely to have serious repercussions on their life, only persons with HIV/AIDS, can make the decision about revealing their HIV/AIDS status, after careful reflection of the possible repercussions.

There is no Vaccine
for AIDS, but there is
a Capsule for a healthy
life. PREVENTION.

Module III

Sub section II

Duration: 1 hour 30 minutes

WILDFIRE GAME

Objectives :

1. To illustrate that one cannot identify an HIV infected person merely by looking at him/her.

2. To illustrate the rapid spread of the HIV infection.

3. To discuss various implications regarding spread and attitudes related to HIV Transmission (personal as well as social).

4. To personalise the experiences and relate to the actual situation in India:

Material needed :

Chalk & blackboard

Group size :

Unlimited (35-50)

Method :

1 Identify two or three participants who would be told that they are to act as HIV positive persons. Each time that they shake hands they are to scratch the palm of the other person. They are not to identify themselves as being infected or tell others. They are to begin scratching only after the facilitator says so.

2 Inform the group that there are some infected persons in the audience whom they should try and identify. After some pause, explain that it is very difficult to conclusively prove that somebody is infected with HIV by merely looking at the person.

3 Now ask the group to shake hands with any three other participants of the group. If during the course of *Handshake* they are scratched in the palm, then they are to scratch the palm

of whoever they shake hands with next. Explain that each hand shake represents an opportunity to pass infection through unprotected sexual intercourse or sharing of needles.

4 After the group has been through the rounds of the handshakes ask them to be seated in their places. Ask all those whose hands have been scratched to either stand up or raise their hands. Count the number of people and explain that one or two persons have been able to spread the infection in such a short time. This clearly establishes the fact that one cannot take chances even if it means your own friends. The virus has already made its presence felt strongly in our country and is spreading like wild fire.

5 Ask all those who were scratched to sit on one side of the room and those who were not on another side.

6 Ask those who have been infected what they felt when their palms were first scratched and later when they scratched the palms of the others. Discuss the responses.

7 Ask those who were not scratched what their feelings were after the exercise was over. Explain that they may not always be lucky and that protection is always required.

8 Ask those who are not infected, what they would like to do with their friends who are infected. You may want to raise issues like isolation, living together, marriage etc. The facilitator should bring in all the issues which were strongly debated by the group in the earlier exercises and point out the change in attitude, if any. Probe also for responsible behaviour (i.e. not scratching after first scratch; irresponsible behaviour (i.e. scratching many with anger) and point out to the group that different people will have different attitudes.

9 You may find people who after getting infected, continue to stay with the non-infected group. Have a discussion on this also. Explain that in real life one cannot identify when a person gets the virus. Knowingly and unknowingly people will be spreading the virus in the country. Thus it is important to talk about prevention instead of isolation.

10 At the end of the discussion explain that this was only a game, and that in real life, scratching palms does not spread the HIV infection and that nobody would have been infected with the virus because of this game. **This is absolutely essential.**

Module : III

Subsection : III **Duration: 1 hour**

IMPACT OF HIV/AIDS

HIV and AIDS can have many levels of impact ranging from the individual to societal, national and international, as well as several types of impact, e.g. social, cultural, economic and psychological. Since it covers many dimensions, it is often crippling to cope with the impact of AIDS. This exercise helps people to identify the nature of this impact in the context of their own lives.

Activity: Exercise on Being HIV Positive

Objective

1. To appreciate the total impact of HIV/AIDS.

2. To personalise the experience of having HIV.

3. To develop sensitivity towards supports needed to reduce this impact.

Material Needed

Chairs in a circle, small square pieces of paper, pen, two wall-charts, pins.

Method

1. Give the participants three small pieces of paper and a pen each.

2. Tell them that a person they know has tested HIV+. Ask them to write down 3 possible consequences for the person that they imagine would occur of his/her being HIV+. Then ask them to write down what would be the consequences for this person's spouse, school-going child and two-year-old sister. (Give no explanation about the nature of the consequence.)

3. Put up two wall charts, one labelled PERSONAL, the other labelled SOCIAL for each of the persons - namely the HIV affected individual, his spouse, child and sister.

4. Explain that PERSONAL is for all consequences that are related to the individual and

the different relatives of the individual who is ill, either at the disease level or the mental-emotional level.

Some examples : "Worries about dying"
"Fear of losing job"
"Being ill in the future"
"Losing immunity"
"No sex life"
"Fear of contracting the disease".

SOCIAL, is for all consequences that are related to people's reactions towards someone who has the HIV infection.

Some examples : "Loss of job"
"Being discriminated at work"
"No friends"
"Inability to marry"

5. Collect all pieces of paper.

6. Call out each "consequence" and ask the participants to decide, to which category it belongs. Some will not fit neatly into either category. Debates and discussions should be encouraged.

7. New categories may be created by the group, such as political, economic, cultural, etc.

Points to be emphasised in the discussion

1. Explore the feelings of the participants when they thought their acquaintance was HIV+, or when asked to imagine the consequences.

2. Explore with the help of the participants, the full-range of possible areas of impact and help the participants to recognise the far-reaching impact. Some questions that could be asked are :

   - How do you think people may react when told they are HIV+ ?

- What kind of worries would they have?

- How would others react to the knowledge that someone they know is HIV+?

3. Place equal emphasis on socially driven impact and self-driven impact, and how these affect one another, e.g. rejection from friends (social) can lead to depression/fear (personal).

4. Actively encourage any positive areas or reactions if they emerge, but do not force them upon the group.

5. Allow the group to dwell on their negative reactions and fears, if any, about working in the area of AIDS prevention, e.g. possibility of burnout, depression, feeling of hopelessness and pessimism, etc. as a worker in the area of prevention.

6. Emphasise :

   - levels of impact, e.g. individual, family, community, work-place, village/town, country, international.

   - types of impact, eg. social, cultural, economic, psychological (practical and emotional).

7. Trace these consequences over time.

8. Identify the required course of action and sources of support, highlighting the positive role of self and others in reducing this impact by using examples, e.g. in the case of loss of job - what if a trust fund is created or the person becomes self-employed or if the spouse/another family member gets a job? **OR** in the case of loss of friends - new friends may be made, more time could be spent with the family, etc. In personal reactions, discuss how this impact of the negative can be reduced, e.g. depression - by reaching out to others who are HIV positive, fear - by finding out more about HIV/AIDS, etc. or finding out how others can play a role in reducing these feelings.

9. Focus on how misinformation and irrational fear on the part of the HIV+ and others is often responsible for this impact.

10. Emphasise the reality that HIV has an impact on every aspect of life of the individual and even the nation, as it cripples development at all levels.

11. Emphasise what we can do for the HIV+persons/persons with AIDS, e.g. support, understanding, companionship, inclusion in our lives, concern, help with practical aspects, keeping their condition confidential, respect, being there, etc.

NOTE :Refer attached Handout : I on Psychological Issues Faced by People with HIV Infection.

Likely Outcome of Exercise

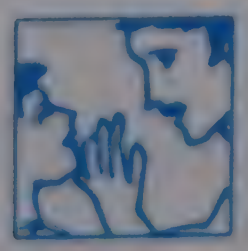
The different levels and types of impact of HIV/AIDS will emerge on introspection as well as on sharing of ideas. The need for acceptance and support, as well as concrete services at the societal level will emerge from this exercise.

IF WE HAVE GOOD
HEALTH ON OUR SIDE
AIDS CAN BE PREVENTED
WORLDWIDE !

Module : III

Subsection : IV **Duration: 1 hour 15 Minutes**

COUNSELLING AND REFERRAL SKILLS



It is important to be able to have an intimate dialogue with those concerned about HIV/AIDS, because of the following reasons:

- Their behaviour could place them at risk.
- They have heard a lot about persons being infected with HIV/AIDS and are worried about being infected themselves.
- They are considering an HIV test.
- They have been diagnosed as HIV+.
- They are family members, friends, colleagues of those who are HIV+ or closely associated with them.

(Give attached Handout: II on "Why is Counselling about HIV necessary ?")

Activity: Counselling and Referral Scenarios

Objectives

1. To accept their role as peer/teacher counsellors.
2. To be sensitised to rudimentary counselling and referral skills.

Material Needed

Several copies of each scenario.

Method

1. Emphasise that they are real scenerios with changed names.

2. Divide the group into 4 groups and give each of them a scenario.

3. Ask them to take on the role of counsellor and counselee and start counselling.

4. Counsellor - counselee roles must be rotated after 10 minutes if possible.

5. Invite the group for a discussion on the content and summarise with the help of the following points - requirement, counselling, points to be considered and points to be emphasised.

Points to be considered

1. There will be some tendency to preach and be judgemental, which needs to be specially guarded against.

2. Getting into a role is not easy. Advice the group that this is a learning exercise and they need to be comfortable.

Points to be emphasised

1. The difference between group advice in most situations and counselling needs to be emphasised.

2. Areas of 'judgemental' assumptions, not listening, lack of empathy need to be pointed out.

3. The need to refer to another agency e.g. hospital, social service department or local agency must be asserted.

4. Areas of ambivalence need to be sorted out, e.g. should one tell the partner that he/she is HIV+, should one tell one's employer that a colleague is HIV+, etc.

Likely Outcome : Some sensitivity to their role as counsellors will be created. Basic skills in counselling others will be gained.

Requirements of Counselling

Time: Some may need more , some less but all need your individual time and attention.

Acceptance: The need to feel accepted is strong inspite of behaviour which you may not approve.

Accessibility: Peer leaders and teachers are accessible to students. This is a key feature in their suitability as counsellors.

Consistency and Accuracy: It is necessary to keep abreast of information on HIV if we have to give it to others or know where to refer to someone for such information.

Confidentiality This is the key term in counselling when no information must be disclosed to any other on what occurs in the counselling context.

Empathetic Non-Judgemental Attitude: It is essential to be able to imagine the feelings underlying the person's dilemma and not pass judgements about his/her behaviour. This promotes an open atmosphere and free sharing of feelings and thoughts.

Careful Listening : One should give a patient ear to the person.

What should counselling do?

1. Give information on HIV and on available resources or provide referral to those who can give such information.

2. Help to clarify complex issues or individual problems e.g. "How do I ensure that my future marriage partner is not HIV+?"

3. Help the person to see how he/she can change his/her life - style in a practical way.

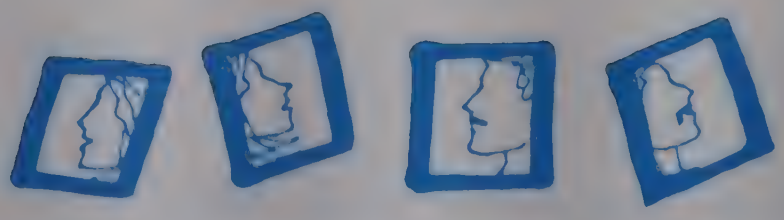
4. Motivate and facilitate decision-making.

5. Help the person to come to difficult decisions, e.g.refuse sex to a boy friend, refuse to go to the red light area with the boys from the hostel, insist on free discussion about the past sexual life by future marital partner.

6. Make the person feel that you understand his/her feelings and support him/her.

7. Make the person feel that he/she is being listened to.

Scenarios



1. *Gopalan* : Gopalan is a 31-year-old man who is an AIDS patient. He works as a mechanic in a public sector organisation. His wife Sita is a corporation social worker. They met 10 years ago. They are from different communities and there was opposition from the parents prior to marriage. Gopalan is now running a continual fever with diarrhoea. He is your neighbour. He and his wife Sita come to you for advice . He is afraid that he is HIV+.

2. *Akshay*: Akshay is a young college student who went for a blood test to a private laboratory and was informed as part of his results that he had tested HIV+. He is very upset, especially since he had not asked for the test. He is also angry because he feels he contracted it from a sex worker and wants to finish the female species by passing the virus to them. Akshay is your classmate and he is sharing plans with you.

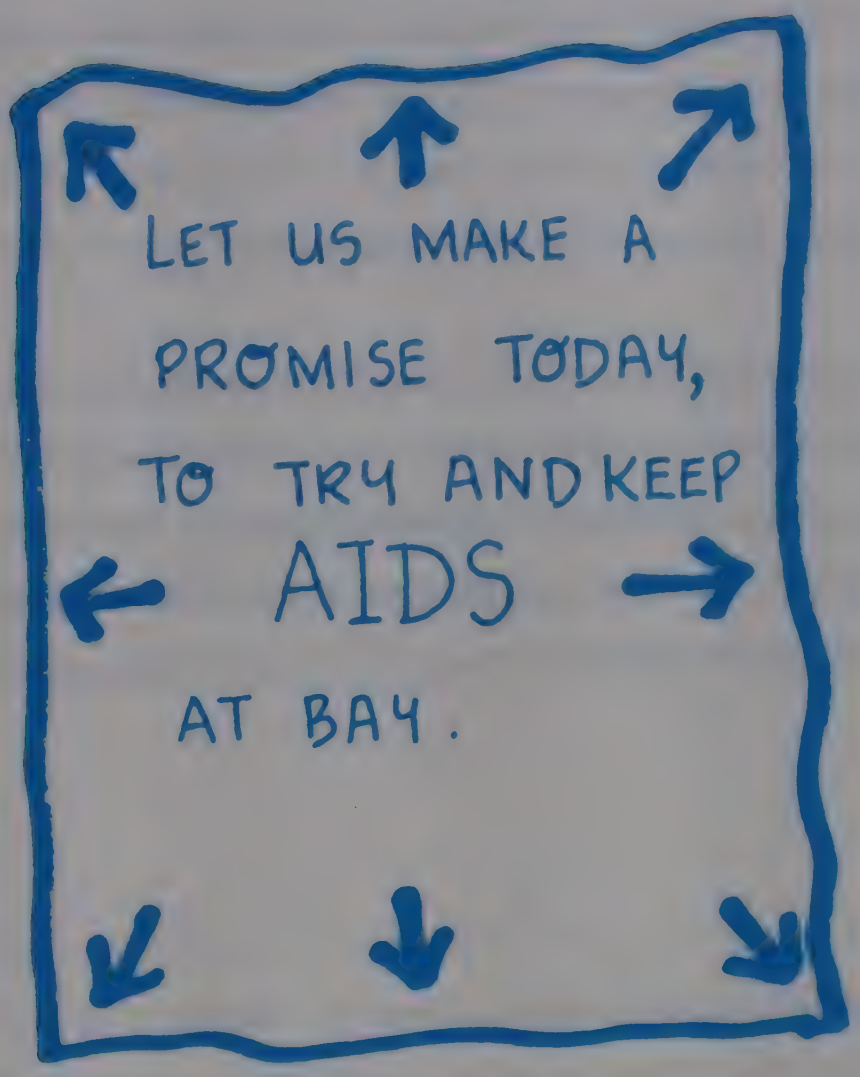
3. *Lata*: Lata, a young 25 year old woman living in Madras, has been married for 11 years. Her husband who had been employed as an electrician in a private company, had been living in Bombay for two years. The couple have three school going children aged 10, 7 and 6. Lata was very unhappy with her husband who had openly started indulging in multi-partner sex in Bombay, which she discovered during her visits to the city. In July 1992, Lata's husband died in an electrocution accident, leaving her solely responsible for their family in Madras.

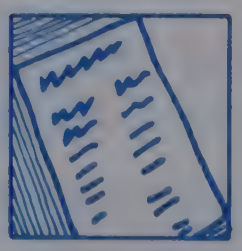
   Three months earlier, Lata was admitted to the Government General Hospital, Madras for piles surgery. She returned for dilation after surgery. The doctors sent her blood sample for HIV testing to the AIDS Cell, and it was found to be positive. It was discovered that Lata had contracted the infection from her husband, who had, in the last year of his life, been continuously sickly and suffering from chronic weight loss. The husband had probably picked up the infection during his stay at Bombay. Lata is your college peon's sister and he has spoken to you about her. You are counselling the peon.

4. *Ramesh*: Ramesh works in one of the five star hotels of Madras at a middle management level. He is 39 years old, happily married, with a 6 year old daughter. In June 1991, he attended a presentation on AIDS, organised at his work place.

   A couple of months later, he and a colleague went on business to a holiday resort in the outskirts of the city. During their stay there, both indulged in sex but with condoms, owing to their prior knowledge of the infection. Unfortunately for Ramesh, his condom burst, and from that point onwards, for the next five months, he lived in a state of fear, depression,

and was angry at himself for having perhaps exposed himself to infection inspite of being aware of the facts. During those months, Ramesh admits that one emotion which he felt above all was guilt on account of having knowingly and unnecessarily exposed himself, and at perhaps having infected his wife. It took him five months of lonely procrastination, doubt, wavering, and self- torture to finally arrive at the decision to seek advice. Ramesh has come to you as he has heard that you are knowledgeable about AIDS.





HANDOUT : I

PSYCHOLOGICAL ISSUES FACED BY PEOPLE WITH HIV INFECTION

The psychological issues faced by most people with HIV infection or disease revolve around uncertainty and adjustment.

With HIV infection, uncertainty emerges with regard to hopes and expectations about life in general, but it may focus on family and job. An even more fundamental uncertainty may concern the quality and length of life, the effect of treatment, and the response of society. All these are relatively unpredictable in terms of their long-term outcome. They need to be discussed openly and frankly, but care should always be taken to encourage hope and a positive outlook.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial (see below). People start to adjust to the news of their infection or disease from the time they are first told about it. Their day-to-day lives will reflect the tension between uncertainty and adjustment. It is this tension that causes other psycho-social issues to assume more or less prominence and intensity from time to time.

Fear

People with an HIV infection or disease have many fears. The fear of dying and particularly, of dying alone and in pain is often very evident. Fear may be based on the experiences of loved ones, friends, or colleagues who have been ill with, or died of AIDS. It may also be due to not knowing enough about what is involved and how the problems can be handled. As with most psychological concerns, fear and the pressures such fear creates can often be managed by bringing them clearly and sensitively into the open. They should be discussed in the context of managing the difficulties, along with the help of friends and family or with the counsellor.

Loss

People with HIV disease experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability

and independence. As the need for care increases, a sense of loss of privacy and control over life is also experienced. Perhaps the most common loss that is felt is the loss of confidence. Confidence can be undermined by many aspects of life with HIV, including fear for the future, anxiety about the coping abilities of loved ones and care-givers, by the negative and/or stigmatizing actions of others. For many people, recognition of HIV infection will be the first occasion that forces them to acknowledge their own mortality and physical vulnerability.

Grief

People with HIV infection often have profound feelings of grief about the losses they have experienced or are anticipating. They may also suffer the grief that is projected on to them by close family members, lovers, spouses and friends. Often these same people are supporting and taking care of them on a day-to-day basis, and watching their health decline.

Guilt

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others, or over the behaviour that may have resulted in the infection. There is also guilt about the sadness the illness will cause to the loved ones and family, especially children. Previous events that may have caused pain or sadness to others and remained unresolved, will often be remembered at this time and may cause even greater feelings of guilt.

Depression

Depression may arise for a number of reasons namely — the absence of a cure and the resulting feeling of powerlessness, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body. Similarly, knowing others or about others who have died or are ill with HIV, and experiencing such things as the loss of potential for procreating and for long-term planning may contribute to depression.

Denial

Some people may respond to the news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter productive, since people may refuse to accept the social responsibilities that go with being HIV positive.

Anxiety

Anxiety can quickly become a fixture in the life of a person infected with HIV, reflecting the chronic uncertainty associated with the infection. Many of the reasons for anxiety reflect the issues discussed above and concern the following:

- Prognosis in the short and long term.
- Risk of infection with other diseases.
- Risk of infecting others with HIV.
- Social, occupational, domestic and sexual hostility and rejection.
- Abandonment, isolation and physical pain.
- Fear of dying in pain or without dignity.
- Inability to alter circumstances and consequences of HIV infection.
- How to ensure the best possible health in the future.
- Ability of loved ones and family to cope.
- Availability of appropriate medical/dental treatment.
- Loss of privacy and concern over confidentiality.
- Future social and sexual unacceptability.
- Declining ability to function efficiently.
- Loss of physical and financial independence.

Anger

Some people become outwardly angry because they feel they have been unlucky to catch the infection. They often feel that they or information about them, has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self-blame for acquiring HIV, or in the form of self- destructive (suicidal) behaviour.

Suicidal activity or thinking

People who are HIV-infected may have a tendency towards suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Suicide may be active (i.e., deliberate self-injury resulting in death) or passive (i.e., concealing or disregarding the onset of a possibly fatal complication of HIV infection or disease).

Self-esteem

Self-esteem is often threatened early in the process of living with HIV. Rejection by colleagues, acquaintances and loved ones can quickly lead to loss of confidence and social identity and thus to reduced feelings of self-worth. This can be compounded by the physical impact of HIV-related diseases that cause, for example, facial disfigurement,physical wasting, and loss of strength or bodily control.

Hypochondria and obsessive behaviour

Preoccupation with health and even the smallest physical changes or sensations can result in hypochondria. This may be transient and limited to the time immediately after diagnosis, or it may persist in people who find difficulty in adjusting to the disease.

Spiritual concerns

Concern about impending death, loneliness, and loss of control may give rise to an interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions.

Many of these and other concerns will appear to become pronounced when a diagnosis of AIDS is made. The appearance of new infections, cancers, and periods of severe fatigue all have a significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.

Social issues

Environmental and social pressures, such as loss of income, discrimination, social stigma (if the diagnosis becomes commonly known), relationship changes, and changing requirements for sexual expression, may contribute to post-diagnosis psycho-social problems. The patient's perception of the level and adequacy of social support is of vital concern and may become a source of pressure or frustration.

HANDOUT : II

WHY IS COUNSELLING ABOUT HIV NECESSARY?

A diagnosis of HIV infection or AIDS, or a suspicion or recognition of the possibility of infection, brings with it profound emotional, social, behavioural, and medical consequences. The subsequent individual and social adjustments required often have implications for family life, sexual and social relations, work, education, spiritual needs, legal status, and civil rights. Adjustment to HIV infection involves constant stress management and adaptation. It is a dynamic, evolutionary, and lifelong process that makes new and changing demands on the infected individuals, their families and the communities in which they live.

Most people are limited in what they can do, or feel they can do, and what changes they can make in their lives. Whether these limitations are real or imagined, they have to be taken into account and dealt with, if behaviour modification is to be successful and sustained.

During the course of HIV infection, a broad range of physical needs and problems are likely to be experienced. These are not constant, but will progressively become more serious and difficult to handle. The changing nature of these needs imposes a variety of psychological and emotional strains on infected individuals and those closest to them. These strains may make the infected person feel that he or she is losing identity, independence, privacy, and social status. They can also provoke guilt, anger, and fear of loneliness, dying and death. Dealing with HIV infection also imposes direct and indirect financial costs, which can be particularly stressful if economic productivity is affected by illness. Much of the stress experienced by people infected with HIV may reflect underlying anxieties about economic independence and family obligations.

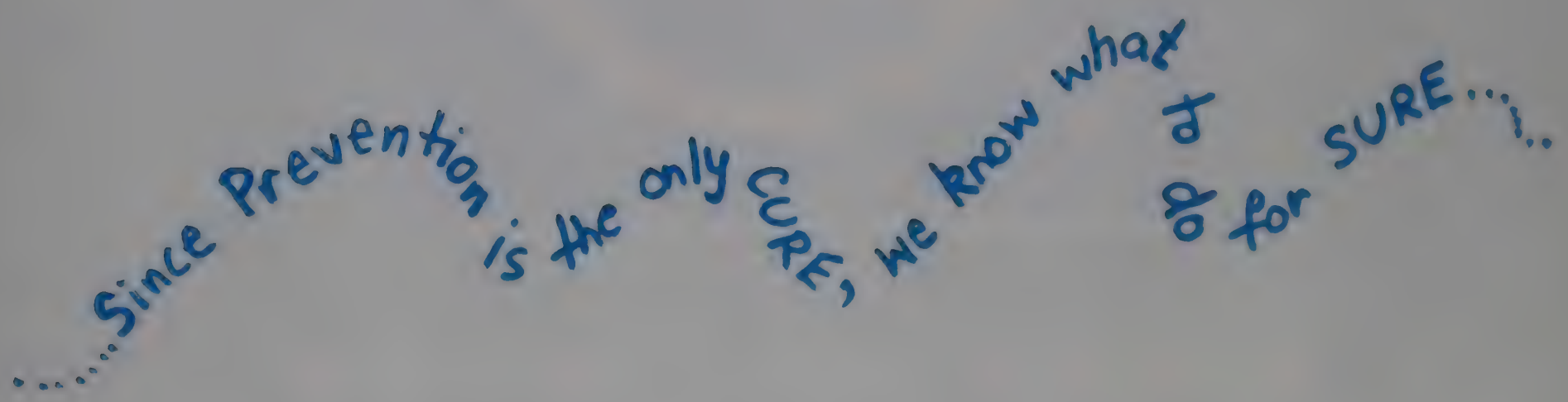
Counselling therefore has to take into account not only the client's immediate social and medical environment, but also his or her social relationships and attitudes and beliefs about HIV/AIDS. Counselling has to provide education and information in a way that is relevant to the day-to-day life of the person concerned. It has to **take account** of such things as the patient's sexual needs and history, occupation, education, aspirations, and hopes, together with what it will take to inspire a new approach to safer sex and responsible social relationships.

Counselling of the family of people with HIV infection and of their lovers, friends, employers, or colleagues, mus provide up-to-date and technically correct information. It should take into account the life-style of the infected person and explore the opportunities for, and constraints on, changes in behaviour and constructive adaptation to HIV infection.

If counselling is to be effective it must be seen by the client as acceptable. Acceptability will be improved if the counselling clearly takes into account the many social relationships, commitments and obligations that the individual has. Each of these relationships may be a potentially motivating and supporting one.

In summary, counselling people about HIV infection is important because:

- Infection with HIV is lifelong.
- A person can avoid acquiring HIV infection or transmitting it to others by changing his/her behaviour.
- Awareness of HIV infection can create enormous psychological pressures and anxieties that can delay constructive change or worsen illness, especially in view of the fear, misunderstanding, and discrimination provoked by the HIV epidemic.



TRAINING MODULE IV

PREVENTION OF HIV/AIDS AND PREVENTIVE BEHAVIOUR

CHAPTER 6

TRAINING MODULE IV

PREVENTION OF HIV/AIDS AND PREVENTIVE BEHAVIOUR

Duration: 6 hours 30 minutes

Subsections

I. Prevention: Role of Behaviour in the Transmission of HIV/AIDS.

II. Assessment of Risk Behaviour.

III. Taking risks and Making Choices.

IV. Skills for Adoption of Preventive Behaviour : Dealing with Peer Pressure.

V. Safer Sex: Condoms.

VI. Benefits of a Long Term Monogamous Relationship

Learning Objectives

1. To appreciate the importance of prevention of HIV/AIDS.

2. To be able to assess risk behaviour.

3. To acquaint oneself with skills needed to adopt preventive or risk-reduction behaviour.

4. To understand the complexities of adopting preventive behaviour.

5. To gain skills in communicating on preventive action without inappropriate, moralising overtones.

Messages to be Conveyed

1. Prevention of HIV is possible if we learn the skills of preventive behaviour.

2. Assessment of risk behaviour can help to make decisions that affect our vulnerability to HIV.

3. Learning skills to say no, to make choices to negotiate condom use and to practice non-penetrative sex is essential for HIV prevention.

4. Abstinence/ delaying sexual activity is the wisest form of HIV prevention.

5. Talking about sexual matters without moralising is the need of the hour.

6. Sex does not always mean penetrative intercourse: love does not always mean sex.

7. Condoms are a part of life and we need to know how to use them as well as all other information about them.

Module : IV

Subsection : 1 **Duration: 1 hour**

PREVENTION : ROLE OF BEHAVIOUR IN TRANSMISSION OF HIV/AIDS

The facilitator must do the following to provide information on how one can protect oneself and others from becoming infected:

1. Review modes of transmission (From Module I)

2. Do exercise on High risk, Low risk, No risk.

Objective :

- To initiate a discussion on the various risk behaviours in the context of HIV/AIDS/STDs prevention.

- To reinforce the modes of transmission and non transmission.

***Activity* : High Risk, Low risk, No risk exercise**

Material needed : statement cards, four large sheets of paper.

Group Size :

Preferably equal to the number of statement cards that are available. Divide into groups if enough facilitators are available or else ask two/three persons to share a statement card.

Time : 45 minutes

Method :

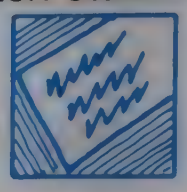
1. Organize the group (s) into a large circle.

2. In the middle of the circle place four large sheets of paper with 'High risk'/'Low risk'/'No risk'/'Don't know' written on them. Write only one on each of the four sheets.

3. Pass out the statement cards to the participants and ask them to decide where they would place the card given to them in the middle of the circle. The 'Don't know' card should only be used very sparingly.

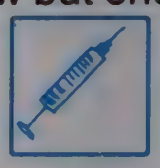
4. As each participant places the card on the floor, one by one, ask them to describe reasons for doing so. Check with the rest of the group whether they agree or diagree. Use the guide given below to summarize discussion on each statement card.

Statements to be written out on separate cards/pieces of paper.



(a) **Having sex under the influence of intoxicants :** This activity is high risk because one cannot be sure whether condoms are used in the first place or used properly in the event of the person remembering to use one. However it would be no risk if it is between two uninfected partners.

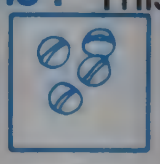
(b) **Having an injection :** This is a low risk activity if needles are not sterilized. The chances of infection through tattoo needles are very low but one must not eliminate the chances of infections, especially in a group situation.



(c) **Buying blood from a commercial blood donor :** This is a high risk activity, especially because the behavioural patterns of the commercial blood donors are not always known and it is possible that the screening of blood might not indicate the presence of HIV.

(d) **Having many sexual partners :** This is definitely a high risk activity as more number of partners increase the possibility of acquiring HIV. Over 80-90% of the HIV transmission in the country would take place through sexual contact.

(e) **Liberated girls are on oral pills, so they do not insist on Condoms :** This is a high risk activity as oral pills are no protection against HIV/AIDS/STDs.



(f) **HIV infected person wanting to have a child :** This is a high risk behaviour activity as the person may transmit HIV to his/her child as well as the spouse, since usage of condoms is ruled out in this case. Moreover, the chances of the child becoming an orphan are high.

(g) **Having sex with a neighbour without a condom :** High risk, as no one can be guaranteed to be HIV free, even if it is your neighbour.

(h) **Caring for someone who has AIDS :** No risk

(i) **Deep kissing :** No risk, as long as both of them are not bleeding in the mouth or have deep cuts/wounds.

(j) **Being bitten by mosquito that has bitten someone with HIV :** No risk. There has been no documented proof of HIV transmission through mosquitoes. Mosquitoes only suck blood and do not inject blood. The HIV virus is a human virus and cannot live in the body of a mosquitc

(k) **Hugging someone who has HIV/AIDS :** No risk

(l) **Having sex with an expensive call girl (commercial sex worker) :** High risk. HIV does not differentiate according to the economic status. It is behaviour that exposes you to risk.

(m) **Oral sex :** Low risk. The chance of HIV transmission is low. Even in such a situation the use of a condom is advocated.

(n) **Anal sex :** High risk. This type of intercourse involves the rectum, which is not naturally designed for sex. During such an act the possibility of wear and tear is great which provides for an opportunity for the virus to enter the body easily.

(o) **Using vaseline/hair oil for lubricating a condom :** High risk. Condoms are made up of latex rubber. Any oil based lubricant chemically reacts on this rubber and may make microscopic holes which is enough for HIV to pass through. Only water based lubricants should be used. Lubricated condoms contain enough quantities of lubricants, however one could use saliva if more lubrication is required.

(p) **Using condom only with wife and not others :** High risk. It will only reduce the possibility of your wife not getting the infection or passing it on to you. You may still acquire the virus from others.

(q) **Using a public latrine :** No Risk

(r) **Sharing needles with a group of injecting drug users :** High risk. Sharing needles will increase the chances of HIV transmission as the needles can contain minute amounts of blood which may have the virus.

(s) **Blood donation :** No risk. Donating blood does not cause transmission of HIV. The blood collecting bags are disposable and sterilized. The youth should come forward and donate blood as it decreases the dependence on professional blood donors. With increase in voluntary blood donation, more amount of HIV tested blood would be available at the blood banks which can be used in emergency situations.

Activity 2

Review modes of transmission and non-transmission.

Method :

Use the slide on checklist of risk behaviour and the following points to discuss preventive behaviour:

(a) Sexual Contact

A person could choose not to have sex. Having sex is a responsible decision and necessitates careful consideration. Sex is something we need to think carefully about, like many other things in life. It is better to delay the decision of indulging in sex, when one is mature enough to take a carefully considered decision. It is important to learn to wait and say no, now.

A person could choose to have sex with only one person, and mutually agree to have sex only with one another. Both will need to know all the facts about AIDS and to have discussed any previous relationships in which either may have been put at risk.

There is no risk of infection sexually, if neither party is infected.

Avoiding penetration and contact with semen or vaginal fluids also lowers risk.

If one chooses to have sex with several partners, the risk of becoming infected increases with each sexual partner. Any act of unprotected sex (sex without a condom) with a person who is infected with HIV could result in the partner becoming infected.

If not sure about one's own or one's partner's HIV status, then the risk to either person can be reduced by using a condom, which fits over the male sexual organ during sexual intercourse. It must be used from the beginning to the end of the penetration and removed carefully, without spillage or breakage.

A condom prevents contact with high risk body fluids - blood, semen and vaginal secretions. Condoms protect against other sexually transmitted diseases and pregnancy as well. If used correctly, condoms offer good protection but they do not make sex 100% safe. For good protection, a new, good quality condom must be used each time. A condom must never be reused.

Most condoms are lubricated i.e., they have a cream like substance. Condoms must not use oil-based lubricants. The condom must be removed carefully and disposed off. Appropriate use of condoms is "protective" behaviour.

When an infected person is engaged in intimate sexual behaviour (contact between penis-vagina, penis-anus, mouth-penis, mouth-vulva, mouth-anus) with an infected or uninfected partner, some behaviours are more "risky" than others. The only "no risk" behaviours are:

- Abstinence which means avoiding intimate sexual behaviour - (oral, mouth-penis/anus contact/sex), vaginal intercourse (male-female sexual organ contact) and anal intercourse (penetration of anus in sex).

- Sex with one uninfected partner or mutual monogamy. In this situation two conditions must be met :

  (a) both persons in the relationship must have intercourse with each other only (mutual);

  (b) both persons must be uninfected.

- Not sharing needles/syringes and using sterilised/ disposable needles and syringes for all purposes.

- Ensuring that one accepts HIV free syringes/blood transfusions, if and when necessary.

- "Risky" behaviours are

  - Unprotected vaginal* intercourse and oral** sex.

  - Multiple sex partners.

  - Sharing needles/syringes/untested blood transfusions.

- Anal*** intercourse (unprotected in particular) because penetration of rectum causes minute tears in the tissues, providing an ideal 'conduit' or passage for HIV.

* Insertion of male sexual organ into the vagina for sex.

** Using the mouth to kiss or carress, the penis and/or the vagina of the partner for sexual pleasure.

*** Insertion of sexual organ into the anus of the partner.

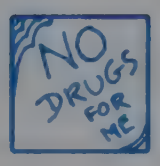
(b) Blood

One can lower risk of needing a blood transfusion by avoiding situations which could lead to major accidents. It is important to avoid drinking and driving. If an injection is needed, one can ensure that the syringe and needle are disposable or properly sterilized and drugs should never be injected especially with shared needles and syringes. All drugs should be avoided.

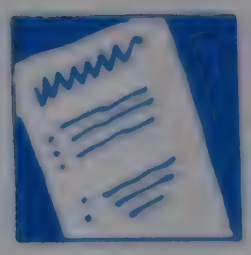
(c) Mother-to-Child

The risk of an HIV infected mother passing the virus to her unborn child is 20-45%, the risk being greater if she has symptoms of AIDS rather than if she has no symptoms. The risk of passing HIV through breast-milk is very small. Breast-milk has many substances in it that protect an infant's health and the benefits of breast-feeding for both mother and child are well-recognised. Bottle feeding is not safe because of difficulties in sterilising the feeding bottles or lack of clean water supplies. In general, the slight risk of an infant becoming infected through breast feeding is thought to be outweighed by the benefits of breast-feeding.

(d) Life- Style Education



It is also important to recognise that we need to be conscious of our life-styles today. Stress is a part of day to day life - stress about exams, unemployment,parental restrictions, choice of career, love relationships,etc. Stress can be handled by turning to easily available escapist routes like drugs/alcohol/sex; violence of all types; theft and other crimes. We may follow short - cut methods to reduce stress. Some may isolate themselves from others to handle their stress. All of these lead us to develop maladaptive or harmful life-styles. Instead, we can adopt positive ways of stress management like engaging in a creative hobby, learning or developing a skill or talking about our problems to others who understand and care.



CHECKLIST OF RISK BEHAVIOUR

NO RISK

Not Injecting Drugs

Abstinence

Intercourse with one mutually faithful, uninfected partner

PREVENTIVE

Oral sex using a condom with a partner whose HIV status is unknown

Vaginal sex using a condom with a partner whose HIV status is unknown.

RISKY

Sharing drug needles and syringes

Unprotected vaginal or oral sex

Vaginal intercourse with infected person

Oral intercourse with multiple partners

Oral Intercourse

Vaginal intercourse with someone you don't know well

Anal Sex

Module : IV

Subsection : II **Duration : 45 minutes**

ASSESSMENT OF RISK BEHAVIOUR

In the case of HIV/AIDS, one finds that categorical answers cannot be given at times. We cannot say if an activity carries no risk of HIV or of another as guaranteeing HIV transmission; we can only talk of risks relative to one another and leave individuals to make their own decisions. It is important to think about the consequences of behaviour and weigh risk factors. It is important to learn to do so.

Activity: Who Is Taking Most Risks?

Objectives

1. To examine the risk factors related to HIV.
2. To be able to assess risk in behaviour.

Material Needed/Arrangements

Copies of four character-sketches for everyone.

Method

1. Divide the group into subgroups of 4-5 persons and give out copies of the character sketches.
2. Allow time for the participants to read them.
3. Ask each individual to rank the 4 people in increasing order of risk of acquiring HIV infection, quickly and without discussion.
4. Ask them, after they have finished, to share their ranking within the small group and discuss the criteria on which they have made their judgements.
5. Have each group produce a consensus ranking, if they can, and justify their decision. Give them half an hour to arrive at some consensus.
6. Bring the group together and ask each small group to report its findings.

Point for Consideration

Assessing risks that others take is often associated with moral judgements, consciously or unconsciously. This aspect needs consideration. It is vital that the facilitator leave his/her personal views on moral living, out of the session. It is important to emphasise risk situations, risk taking and risk behaviour, without subtly promoting moral righteousness. The facilitator needs to be aware that this moralising may occur inadvertently and watch out that it does not happen.

Points for Emphasis in Discussion

1. Identify what specific factors were given greater importance in assessing a behaviour as risky by different groups. Was it the behaviour of the group to which they belonged? If so, what is the specific behaviour?

2. Discuss differences in ranking between groups trying to identify why these differences occur e.g. the tendency to mix up risk behaviour with the group to which they belong.

3. Explore the discussion of the group, to arrive at a consensus and the basis on which the consensus was reached.

4. Discuss whether moral judgement about risk behaviour affected risk-as essment.

5. Emphasise, that it is the behaviour that needs to be considered and the relativeness of risk in assessment.

The ranking is as following : Chandrashekar-1, Pratima-2, Dolly-3, Jasjeet-4.

Jasjeet is taking the least risk as he has resolved that he would not be taking drugs any more.

Dolly too is taking precaution because she has heard of AIDS. She ensures the use of condoms, but then they are not 100% fool proof. So she is still taking some amount of risk.

Pratima on the other hand is at a higher risk situation because she is having sex with her husband who has another partner. This partner too has several other partners. Further, Sharad does not use a condom, because he has undergone a vasectomy operation, thus has no fear of pregnancy.

Chandrashekar is taking the most risk as he is practicing anal sex (homosexual relationship) and does not care about HIV/AIDS even though he has heard about it. This places him at highest risk.

* **Note** Some groups may rate **Pratima** as No 1 as she is defenseless and as a woman is more vulnerable. In such a situation point out that there is thin line of difference between Chandrashekar and Pratima.

Likely Outcome

The group will develop some capacity to assess risks and realise that moral judgements and biases may affect risk assessment. It will understand the importance of weighing risks in behaviour.

Character Sketches for Who's Taking Most Risks?

Chandrashekhar, Pratima, Jasjit, Dolly

Chandrashekhar is married but has occasional sexual relations with men. The men he has relations with are often not known well to him. Chandra has heard about AIDS and is aware that he may be HIV+. He sees no point in testing himself for HIV because fate will decide his future. However, his wife,Revathi is not aware of his relations with men and has never slept with another man. She suspects that he is not faithful to her, but keeps quiet about it. They have been using condoms in their relationship since their marriage, three years ago.

Pratima has been married to Sharad for 15 years. They have 2 children. After the birth of their second child, Sharad had a vasectomy, so they no longer use any form of contraception. Sharad travels a lot for work related matters. On one of his trips, he meets Priti an old girlfriend and begins a sexual relationship. Whenever he visits her town, he meets her. Priti is not keen to break up Sharad's marriage. She does not feel guilty about her friendship with Sharad and has other boyfriends, as well.

Jasjeet is 18 years old. He recently broke up with his girlfriend because her parents want her to marry somebody else. One of his friends invited him to a party where he got very drunk and injected drugs, at the persuasion of a few friends. He has never done it before, and doesn't want to do it ever again, because he felt very sick. Now he is worried about getting AIDS.

Dolly is a call girl in a metropolitan city. She first heard of AIDS two years ago. She was so frightened by what she heard that she seriously considered giving up her vocation. However, once she had thought over it, the panic reduced and realism took over. She had to earn her living somehow. She refuses to have sex with any man, who will not use a condom.

Module : IV

Subsection : III **Duration: 1 hour**

TAKING RISKS AND MAKING CHOICES

In life one has to take risks and make several choices that are not easy. However, one has to make choices that involve minimal risk and take risks only worth taking. Group pressures may influence what one thinks but eventually, one has to take the decision on one's own. In relation to HIV, there are major risks that one needs to avoid, and take careful decisions when situations arise. This game will expose the risks one takes in life and the risk of HIV infection, to the participants.

Objectives

1. To be sensitised to the process of difficult decision making.

2. To distinguish between reasonable and unreasonable risks.

Activity 1 - Making Choices

Additional Objectives

1. To evaluate common behaviours in terms of relative risk of HIV infection.

Material Needed

Enough copies of the list, one pen/pencil for each member.

Method

1. Hand out the list and ask the participants to read them. You can give clarification if needed.

2. Ask them to mark the items according to how harmful they think each behaviour is in terms of whether it puts a person at risk for HIV infection on a scale of 4 with 1 being very harmful and 4 being not harmful.

3. They should do so without discussion of their answers with anybody else.

4. Arrange them in smaller groups and discuss their responses and arrive at a consensus.

5. Discuss each group's response in a plenary session.

Points to Emphasise in the Discussion

1. Start with requesting the participants to volunteer which activities they have placed at the most harmful end of the scale and which they feel is the least harmful in terms of HIV infection.

2. Explore why they consider them so.

3. Particularly, explore why some are not seen as 'somewhat' or 'little' harmful.

4. Discuss differences in opinion and why they occur, i.e. how some see an activity as harmful but others do not.

5. The discussion needs to be concluded with filling in the gaps noted by facilitator on the group's information on high risk behaviour given in the earlier subsection 'Role of Behaviour in the Transmission of HIV/AIDS'.

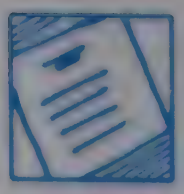
Likely Outcome

The group will be sensitised to the reality that we need to evaluate risks all the times in life. It will also make them aware of what risky behaviour is, in terms of HIV.

We won't give up without a fight

we'll prevent AIDS with all our might.

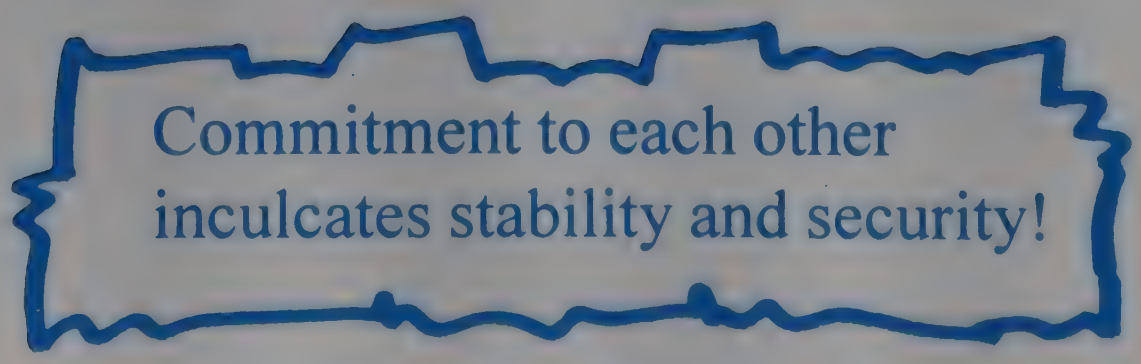
List for Making Choices



Circle the number that represents how harmful you think each of the following behaviours is. (Use number 1 for a behaviour that you think is very harmful in that it is most likely to put a person at risk for HIV infection and number 4 for a behaviour that you think is not harmful, in that it does not put a person at risk of HIV infection).

		Very harmful	Somewhat harmful	A little harmful	Not harmful
1.	Smoking ganja/ charas/bhang	1	2	3	4
2.	Getting drunk	1	2	3	4
3.	Moderate drinking of alcohol	1	2	3	4
4.	Lack of exercise	1	2	3	4
5.	Feeling guilty	1	2	3	4
6.	Poor eating habits (types of food, when, how you eat etc.)	1	2	3	4
7.	Going to a party where people are drinking or using drugs	1	2	3	4
8.	Using drugs which need to be injected	1	2	3	4

9. Sharing needles used to inject drugs	1	2	3	4
10. Overwork	1	2	3	4
11. Having un-protected sexual inter course (without condoms)	1	2	3	4
12. Lack of medical attention when necessary	1	2	3	4
13. Nervous anxiety and tension	1	2	3	4
15. Having sexual intercourse with someone you have known for a long time.	1	2	3	4



Module : IV

Subsection : IV **Duration: 1 hour, 45 minutes**

SKILLS FOR ADOPTION OF PREVENTIVE BEHAVIOUR

Dealing with Peer Pressure

An important aspect of being able to adopt preventive behaviour is being able to handle peer pressure - pressure to engage in behaviour that could expose one to the risk of HIV transmission. This involves refusal to participate in drinking and taking drugs, engaging in paid sex or any other form of sexual activity and general risk-taking behaviour. While this may be a specific problem for young people, it is a problem that cuts across most age groups. It is therefore, important to learn to deal with peer pressure by learning specific strategies and practising them. In the process, one becomes aware of the intricacies of adopting preventive behaviour.

Activity: Exercise on Learning to Refuse

Objective

1. To learn specific ways of refusing.

2. To recognise the need to deal with peer pressure, when it may lead to harmful consequences.

Material Needed/Arrangements

Adequate open space, handout (attached herewith), chart paper, sketch pens, pins and felt board, sticking tape.

Method

Get together in groups of 3 to 5 and read the handout (15 mins). Then do the following:

Activity 1

1. Distribute different scenerios to each group.

2. Take the scenario given to your group and discuss how any of the ways to say 'no' can be applied and how (10 mins).

3. Role play the group's ideas to show what it would look like. (Time for planning : 25 mins., conducting : 5 mins. for each group).

4. At the end of each role play, any of the other groups (or any one pre-determined group) can try out an alternative strategy for the same situation.

Points for Consideration

1. The groups need not stick to the ways suggested in the hand-out. New ways and a combination of ways provided may be used.

2. Determine the size of each group, depending upon the whole group e.g. for 20 participants one can have 4 groups of 5 members each.Avoid more than 5 members per group.

3. Encourage participants to share how they themselves felt about refusing and why.

4. Discuss why people would find it hard to challenge someone in a real-life situation and why.

Points for Emphasis in the Discussion

1. Assert that people have difficulty refusing even when they know it is good for them to refuse.

2. Clarify that refusal is not easy and that it needs support from others but that **is** possible. Emphasise that in some situations and with some people, it is particularly difficult, but practice helps.

3. Do not encourage any particular way as correct or incorrect, but emphasise that different strategies may work; what is needed is the repertoire and the confidence to say 'no'.

4. Ask group members which techniques seem to work and which do not seem likely to succeed, and why.

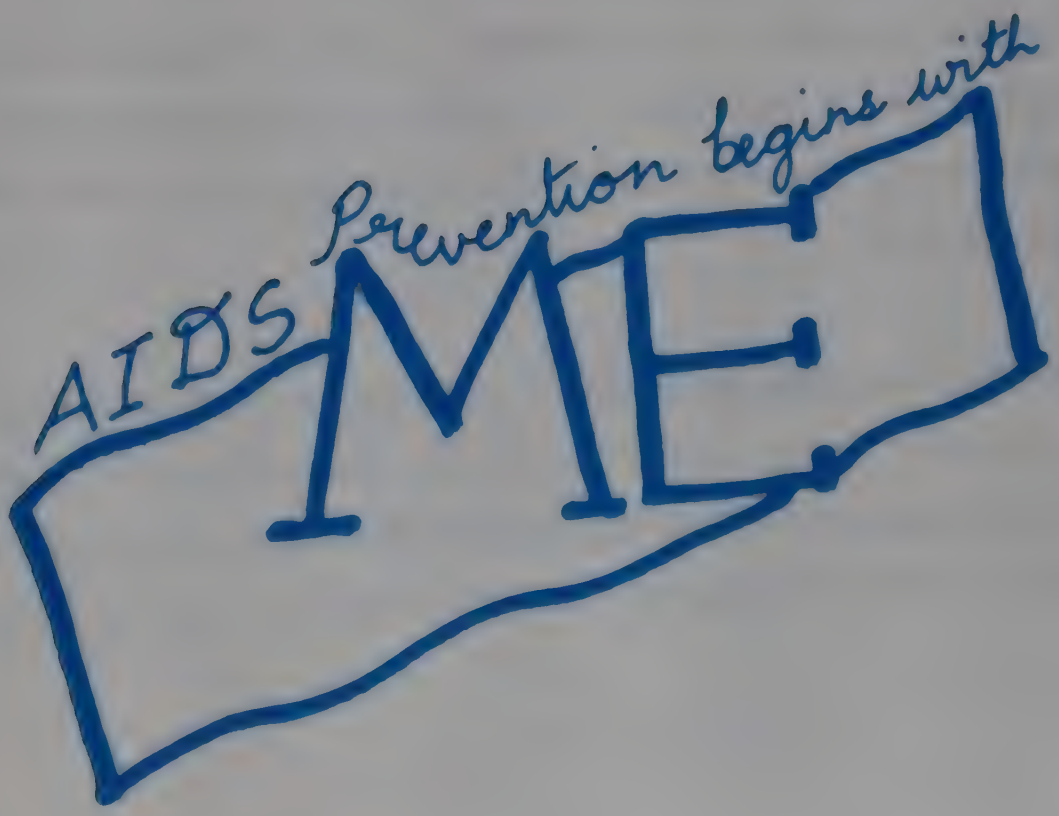
5. Elicit other ways to refuse from the group itself and write them down on a chart paper. Pin the chart paper to a felt-board or attach it with sticking tape to a wall.

6. Encourage the group members to add to the list, more ways to refuse.

7. Get the list photocopied/typed and hand over to the group, later in the session.

Likely Outcome of Exercises

The group members will learn concrete ways of dealing with peer pressure when it pushes them towards harmful behaviour and the difficulties encountered in practising these ways. They will also learn from one another new ways of learning to refuse, and the skills needed in practising them. This activity will also emphasise the need to say 'no'.



Scenarios

1. *Rajesh* is going out with his friends to a party. When he gets there, he realizes that there is a lot of drinking going on and several people are quite 'high'. Some drugs are also being passed around. The friends he is with, have known him for many years as he is very close to them. One of them comes to Rajesh with a glass of alcohol and says that he'd like Rajesh to have only this glass,if Rajesh is really his friend.

2. *Jacob* has just come to live in a new town and has been invited by his office colleagues/ neighbours/college friends to their place. After a good meal some of the men talk of taking a drive around the town to show Jacob the place. One of them winks and says, that they will show him the 'interesting' spots around town that every single person should know.

3. *Rebecca's* parents are out of town and she has the house to herself. A few of her friends visit her and stay over till it is quite late. When finally they begin to leave, Ashish who does not seem at all keen to leave, asks her if she would mind if he left a little later, since his parents who had gone out after locking the house, were returning only after 11.30 p.m. He has given Rebecca several hints throughout the evening that he likes her more than the other girls.

4. *Tariq* stays in a youth hostel. The men have some privacy in their rooms and there are rumours that drugs are being taken on the premises. Tariq receives news that his girlfriend is marrying another man and is very upset. He walks into Rohinton's room and finds him getting some apparatus ready. Rohinton offers him a new drug that relieves tension and pain but is reportedly not addictive.

5. *Aarati* has few friends and has difficulty getting along with her parents. She is an only child and spends a lot of her time alone. Ajeeth lives in the neighborhood and has grown close to her. She likes him, too. Ajeeth invites her to a friend's place who is out of town. Ajeeth also assures her that he loves her too much to get her into any kind of trouble.

HANDOUT

WAYS TO SAY 'NO'

You have heard it a thousand times - "Just say no." It sounds easy, but in fact there are many times when it's hard to say `no' to someone. If people are pressurising you into something you don't want to do, they may try to make you feel as if there is something wrong with you if you say `no'. When the pressure is on, you may get confused about what you really want. It's important to remember that if they are pushing you, then they have a problem, NOT YOU. By telling them how you feel, you are remaining true to yourself. Here are some ways you can say "no" when that is what you want to say.

Polite Refusal

"Can I get you a drink?"

"No, thanks"

Give a Reason

"How about a beer?"

"I don`t like beer"

Broken Record

"Here, smoke this joint with me"
"Come on!"
"Just try it, chicken!"

"No, thanks"
"No, thanks"
"No, thanks".

Walk Away

"Hey, do you wanna buy some brown sugar?"

"Say `no' and walk away while you say it"

Cold Shoulder

"Do you want some brown sugar?"

Keep going as if you did not hear the person (Not the best to use with friends)

Give an Alternative

"Let's go upstairs to my room."

"I'd rather stay here and watch T.V. "

Reverse the Pressure

"C'mon, just come upstairs with me"

"What did I, just tell you? Were you listening?"

Avoid the Situation

If you know of people or situations where people will pressurise you to do things you don't want to do, stay away from these situations.

Strength in Numbers

Hang around with people who support your decision not to drink, use drugs, etc.

Owning Your Feelings

"There is no problem doing this- do it for my sake !"

"I am not comfortable doing this."

"It makes me unhappy."

YOUNG PEOPLE
OF OUR COUNTRY MUST
UNITE AND FIGHT
THE MENACE OF
HIV / AIDS
POWER

Module : IV

Subsection : V

Duration: 1 hours 15 minutes

SAFER SEX:CONDOMS

Safer sex is way of adapting your sex life to minimize the risk of giving or getting HIV infection. It embraces the whole range of sexual activities, making the minimum changes necessary to make them safer. It is called "safer" rather than "safe" as it involves greatly reducing risk, rather than completely eliminating it.

It has been emphasised via the introductory lecture that using condoms correctly every time from start to finish in sex is the best way to stay protected from AIDS and STDs. However, knowing this information is not adequate as protection, skill in using the condom and comfort while talking about it is important. Both are not always evidenced. People, especially young people may be embarrassed to ask about proper use of condoms and raising their difficulties, doubts, anxieties and negative experiences in discussion. Humour and a lighthearted, non-moralistic appropriate approach are essential to release the embarrassment. The exercises in this subsection, deal with the use of the condom and aim at release of the embarrassment related to talking about condoms.

Activity 1 - Condom Discovery

Objective

1. To get comfortable with condoms.

2. To get answers to questions about condoms in a funfilled environment and with hands-on experience.

Material Needed

Five to six pads of notepaper, pencil for each, twelve condoms, prepared instruction boards, pins, a bell/whistle.

Method

Part A

Make an opening statement, somewhat like below, interspersing it with your own experiences, e.g. the first time you found what a condom was the misconceptions you had, how you felt when

you had to do a similar exercise, etc.

"In this session, let's talk about condoms and how to use them correctly, if one has to have sex. Let me add that staying away from sex and using it responsibly is the best option. But you also need to know what to do if you are involved in a situation where sexual activity is to occur or when you have to advise somebody on this aspect. It is very important that at the end of this day, you become comfortable with condoms and know how one can protect oneself from AIDS. That means knowing how to use condoms and then using them when the time comes to do so - whenever that will be, and being able to talk to others about it.

Different cultures and religions have very different views about condoms and whether it is allright okay to talk about them or use them. We believe that knowing about condoms and how to use them doesn't say anything bad about you personally - it means you care about your health and about protecting yourself and others from AIDS, STDs and of course, unwanted pregnancy.

Optional Activity for Peer Leaders

Part B

Ask some questions

a) Name at least two places where condoms can be obtained.

b) How much do condoms cost?

c) Name the brand names of condoms you know.

d) Have you heard people talk about them? What were they saying? (If no responses come, ask them to write down and repeat).

Activity 2 - Condom Demonstration

Objective

1. To learn more about condoms and specifically on how to use condoms.

2. To be able to explain and demonstrate condom use to others.

Material Needed/Arrangements

Display tray, condoms (at least a dozen) of different types; plastic models of the penis or alternatives like cucumber, carrot, etc.; a pictorial description of condom use with written explanation for each participant.

Method

1. *Introduction:* Tell them that knowing about condoms, handling them, seeing condom ads does not mean that we know how to use them or how to explain to others how to use them. Explain that in the next half an hour, the group will be doing that. Encourage them to stop you and ask questions.

2. *Demonstration*: Take out the display tray and show the variety of condoms. You can say something as follows -

   - ❑ All condoms are not the same. Latex is the **only** kind of condom that prevents HIV from going through it.

   - ❑ Lubricated condoms should be used to protect against HIV/AIDS virus. Today most condoms available are lubricated.

   - ❑ Most condoms available in India have a small reservoir tip or teat at the end to collect the semen at the end.

   - ❑ Condoms are usually good for 2-3 years from the date stamped on the package, which is the date of manufacturing, if they are kept in a cool, dry place. Keeping condoms in a hot/moist place like wallets, purses, etc. for very long damages them.

   - ❑ Condoms can be bought in chemist shops, in 'pan-beedi' shops, general stores or provided in government clinics, family planning clinics, primary health centres and most government health centres. This is at times seen as embarrassing but today one needs to walk in comfortably and get a condom (can show newsclip of a client buying a condom at a chemist's). Don't allow embarassment to stop you. Priced differently and packaged differently, the main thing to ensure is that they are lubricated and not stored poorly and/or for too long. The rest is personal choice and preference.

how to use a condom

Open sealed wrapper with care. Take care not to damage the condom. If you do damage it.. USE ANOTHER!

The teat is important! It is for the semen. If there is no teat.. make one by pinching the end of the condom

Squeeze the air out of the teat. If you forget to do this, it may break. Put rolled-up condom onto tip of erect penis like a little hat.

Unroll down the entire length of the penis.

Add a blob of WATER-BASED lubricant.. K.Y. Jelly or Duragel

NOT Vaseline as it destroys rubber!

After ejaculation, withdraw penis before it goes limp.

Hold base of condom in place on penis to prevent spills

Tie knot in condom (after taking it off!) Wrap it in tissue and flush it away or put it in a bin.

3. Invite participants to come forward and do condom demonstration based on their existing knowledge.

4. After a few participants have finished tell the group that you are now going to demonstrate the proper way.

Purchase : The expiry date should be checked before purchase and should be stored in such a manner that the condom does not get damaged. Avoid keeping in the purse or back pocket.

Storage at home : Keep the condom in such a place where it is not in reach of children and at the same time convenient for you to have access to it when you need it.

Opening the package : The package should be opened from the middle so that the condom does not get damaged. Care should be taken that nails or sharp instruments do not tear the condom.

Unrolling the condom : Remove the air from the tip of the condom and gently roll the condom to the base end of the penis. Ensure that no air is trapped inside. This may cause the condom to burst.

Removal of the condom : After the sexual intercourse, the condom must be removed while the penis is still erect. One must be careful that the contents do not fall off while removing the condom. Tie a knot of the condom before throwing it off.

Disposal : The condom should be disposed off carefully. Either flush it down the toilet or wrap it in a paper and throw it in the garbage.

A condom should be put on only after the penis is erect and during the entire period of intercourse.

NEVER USE A CONDOM TWICE

5. *Group Participation/Reinforcement :* Ask for volunteers to go through the steps again. Watch carefully and offer help when needed. If no participant volunteers, draw lots.

6. *Questions to Wind up Session*

a. How did you feel about this activity?

b. Did you feel strange or uncomfortable? If so, with what?

c. Different cultures, religions and families have different ideas about whether it's okay to use condoms and talk about them openly. What are your experiences about this?

d. What are some of the barriers on condom use and its acceptance? (Refer note.)

e. Do you feel differently about condoms than you did before? If so, how have your ideas changed?

Points to Consider

The group is likely to feel embarassed during this activity. Encourage participants to share their embarrassment and discomfort and its source. Welcome participants to talk about their homes, culture, religion and encourage the group to be open to accept different ideas. Be sure that you are yourself very comfortable.

Points to Emphasise

The steps have emphasised the specific points to be covered:

1. Emphasise that this session is for learning facts without hesitation or embarrassment; as an important step towards AIDS prevention.

2. Note that in safer sex, abstinence also plays an important role, as does non-penetrative sex. Hence, the following sessions will focus on these aspects.

Likely Outcome of the Exercise

The participants will understand the correct use of a condom and will be able to explain to another, the steps involved. This exercise may reduce some of the anxiety and embarrassment not handled in the earlier session.

Note to Facilitator

Barriers to Condom Use and Acceptance in India

Social attitudes are a major stumbling block to condom use. Embarrassment about buying/asking for a condom is the first barrier but it can be bought even in general stores, increasing the invisibility of the customers. People also believe that condoms interrupt sexual activity and reduce pleasure. Condom use, however, prolongs the period between sexual arousal and climax/ ejaculation , which may be seen as a plus point by some and is not known to many. Inadequate /incorrect knowledge about how to use, remove and store and dispose the condom also remains a problem. Some people fear that the condom may remain within the vaginal passage.

Storage is a problem due to lack of privacy, and disposal difficult, as trash-cans are often not closed and rummaged by scavengers. Condom packets do not provide knowledge about how and when to put on a condom and remove it. Leakage or breakage, spreads the fear that condoms are ineffective.

The major barrier, however, is that men who generally buy and use the condom, find that it reduces pleasure in sex. They thus prefer that women use a contraceptive device. Women, due to the cultural position they occupy, cannot promote condom use either.

Some religious groups also do not accept artificial birth control and they reject condoms. According to most Indian studies, doctors do not promote condom use even for STD prevention. Thus, condoms are not used for prevention of STDs to as large an extent as needed. In long-term relationships condoms may be used initially but couples soon turn to female contraceptives or sterilization, after having achieved the desired family size.

Thus, condom use is not popular in India in spite of its heavy promotion as a contraceptive device and relatively easy availability.

Module : IV

Subsection : VI **Duration: 45 Minutes**

BENEFITS OF A LONG TERM MONOGAMOUS RELATIONSHIP

Like many other parts of the world, we also inherit a very rich social system and cultural values. The institution of marriage, the value attached to family and respect accorded to fidelity, commitment and mutual relations are very deep rooted in the peoples' psyche in our country. In the absence of a vaccine against AIDS, these positive traditional values need to be re-emphasied in a manner so as to make people feel proud of its practice.

As has been pointed out, abstaining from sexual intercourse is the most effective way of avoiding HIV/AIDS/STD infection. The best alternative to sexual abstinence is to be a member of a long-term, mutually monogamous relationship with an uninfected partner. Consequently, it is important for the youth to consider the benefits of monogamy, fidelity, and commitment in long-term relationships.

Points to be considered

In this activity, the trainers will orient students how to interview people in their lives or others they know who have been in long-standing committed relationships. It is important to discuss with students how to select good interview candidates, how to request an interview, and how to ask questions that are incisive yet not too personal. Some students may feel that this activity is intrusive. Apart from the substantive content of this exercise, it is helpful for such students to learn that many people enjoy talking about their lives, that they actually benefit from reflecting on their pasts; that having participated in a long-standing, committed relationship, they have much to share about the benefits of monogamy, and that this process is a vital way in which values are passed from one generation to another. In short, the exercise should be presented as a mutually beneficial stimulating activity for both the interviewer and the interviewee.

Life-long relationship : Significance

This activity gives trainers and trainees an opportunity to reflect upon their community's value regarding monogamy and mutually faithful relationships.

Specific objectives

1. Identify the personal qualities that sustain relationships of commitment and fidelity.

2. Recognize the significance of having a stable, loving, monogamous relationship.

Material needed/Arrangement

1. Make copies of Handout 5, "Case History : Reflecting on a marriage of twenty eight years". Check the vocabulary and treat the difficult words as you normally do in other exercises to make sure students understand them.

2. Be prepared with ideas for a short list of questions students can ask during their interviews, in case they need help generating questions.

3. As an alternative to individual interviews, consider asking one or two people with experiences of successful married lives to come in and talk with the class about their relationships. Invite people to whom you think the students can relate. These people (ideally, a man and a woman, not necessarily themselves a couple) should come to a class after students have had the opportunity to discuss the case history and prepared questions.

Points to be Emphasised in the Discussion

1. List major benefits of long-term committed relationships such as marriage.

2. Define *monogamy*, *fidelity* and *commitment* (see glossary).

3. Explain the importance of commitment and fidelity.

4. Explain how the HIV epidemic makes long-term monogamous relationships extremely important.

Method

1 Review with students/trainee the meaning of the terms *monogamy*, *fidelity,* and *commitment* as listed in the glossary. Students should understand that *long-term* means that both partners enter the relationship believing it will last a lifetime.

Emphasize that long-term, committed, monogamous relationships are important for many reasons — personal, social, financial, and religious. Now more than ever, these kinds of relationships are important because they protect us from a major threat to our health : HIV infection.

Tell student/trainee : In this lesson we are going to explore the specific reasons people choose and value this kind of relationship.

2. Distribute the case history. You may want to read it aloud, as if the person who related it were in the room.

3. Discuss the case history, using the discussion questions provided and any other questions you think are appropriate.

4. If students will be conducting interviews outside the classroom, tell them they will be asked to interview someone they know who has experienced a long-term, committed relationship (usually a marriage). Students should understand that long-term means a long lasting relationship. Discuss with students/trainees such issues as:

- ❑ What they might hope to learn from the interview
- ❑ Whom they might interview (family members? neighbours?)
- ❑ How they might begin the interview

Suggest that students say, "Our class is exploring the reasons people want to stay in long-term relationships. I would like to talk to you about your relationship with your [partner, wife, husband]. I won't use your name, and you don't have to answer any questions you don't want to." If the person consents to the interview, students can ask," Is this a good time to talk?" If the person then responds that he or she is too busy at the moment, students can ask, "When would be a good time?"

In a final brainstorming session, tell students/trainees: If you worked at an advertising agency, how would you create a slogan, poster, or TV ad that conveyed what was most important to the people you interviewed about long-term, committed relationships? How would you try to tell young people why these relationships are so desirable and important?

Suggested questions:

- ❑ When you got married [or entered this relationship], did you feel it was for life? How did you know?
- ❑ What is good about being in a long-term, committed relationship?
- ❑ What difficulties have you encountered, and how have you managed them?
- ❑ In what ways have you changed since becoming a partner in this relationship?
- ❑ What should I want from this kind of a relationship? Why should I wait for this kind of a relationship?
- ❑ What is the most important message you would give young people today about the value of a long-term commitment to one person you love?

HANDOUT

CASE HISTORY : REFLECTING ON A MARRIAGE OF TWENTY EIGHT YEARS

Neena and her husband Kabir have been married for 28 years. They have two daughters. Neena talks about what has helped her marriage succeed: commitment and work, as well as love.

"I think a couple must be committed to the idea of commitment, as well as to each other. In other words, each should be able to say that things work better for them when they are together than when they aren't together, even when things aren't going well, especially when things aren't going well.

That kind of decision lets you say, 'I was wrong, I made a mistake,' and be sure the other person won't say, 'Well, that's your second mistake this month. I've had it with you.'

You can tolerate differences, too. My husband thinks it's a sin to stay in bed after 6:30 in the morning. I like to stay in bed as long as possible. On a holiday, my husband prefers to visit relatives and friends, whereas I want to spend my time with the children and also do some household chores. He wishes that I'd clean the refrigerator more often, and I wish he wouldn't throw newspapers all over the living room floor. I want him to accompany me when I go shopping for household items, but he prefers to stay at home and watch the television. But we can accept the differences and keep them in proportion, and even tease each other about them.

Our children have been a cause of common concern in our marriage, which is a key factor in further strengthening our commitment towards each other.

Of course we've been very fortunate, too. We've never had to face some of the terrible events that some other families deal with. We've been healthy, the kids are doing well, we have enough money to pay the bills.

Marriage isn't a fairy tale, although there are many magical moments. 'Living happily ever after' takes work, sometimes compromise, always a sense of humor, and a sense of proportion, along with a lot of love. But it's worth it."

For thought and discussion :

1. What is your reaction to the idea that people must be " committed to the idea of commitment"? What other principles or ideas seem important to a relationship?

2. Neena says, "We've never had to face some of the terrible events that some other families deal with." Think of some events or problems in other families you have known. In what ways can people help each other with these problems? And if people cannot get help from other family members, where can they turn to?

3. What do you think are the advantages of a long-term relationship?

Glossary

Monogamy : Practice or custom of being married to only one person at a time.

Fidelity : The state of being faithful/loyal to a partner by having no other sexual partners.

Commitment : An engagement or obligation that restricts freedom of action.
The process or an instance of committing one self, a pledge or undertaking.

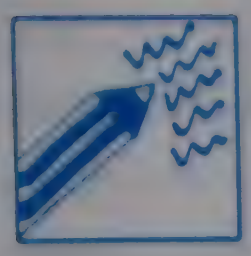
"Young people are increasingly seen as real agents of development rather than merely passive recipients of it."

(From United Nations Documents on International Youth Year - 1985)

TRAINING MODULE V

COMMUNICATION SKILLS

CHAPTER 7



TRAINING MODULE V

COMMUNICATION SKILLS

Subsections **Duration: 1 hour**

I. Need and Objective of Communication

Learning Objectives

1) To understand the essential components of effective communication.

2) To become equipped with skills necessary to impart information on HIV and sexuality to student youth.

3) To increase self-awareness of personal communication — strengths and weaknesses.

4) To explore one's inherent, subconscious attitudes and values that may interfere with one's interactions if left unattended.

5) To practice and increase one's repertoire of effective communication methods.

Note : Warm-up exercises 1 to 5 in the annexures are supplementary to Communication Skills Module and may be used at different stages of the programme.

Module : V
Subsection : I

Duration: 1 Hour

NEED AND OBJECTIVE OF COMMUNICATION

Introduction: People who are in the process of developing their communication skills need to have a theoretical and experiential understanding of the aims and desired results of communicating to groups. The first step of a communication endeavour is information and education. This then is built upon by motivating the target group to examine their attitudes and world views. Attitude change is a natural outcome of effective communication and awareness building. And, finally, it is only when an internal shift occurs in an individual's values and belief systems, that an external, observable behaviour change is attempted by the person. Once an individual takes steps towards changing his/her behaviour towards reducing risk of HIV transmission, the goal of the nationwide AIDS awareness efforts will have been met in that person or group.

Specific Objectives

1. To appreciate the importance of communication in behaviour change.
2. To learn about different kinds of communication.
3. To practice role plays to demonstrate objectives achieved via effective communication.
4. To understand the impact of effective communication on target audiences.

Material Needed

Transparency on Behaviour Change, chart paper, black board, chalk, OHP.

Group Size

Unlimited.

Method

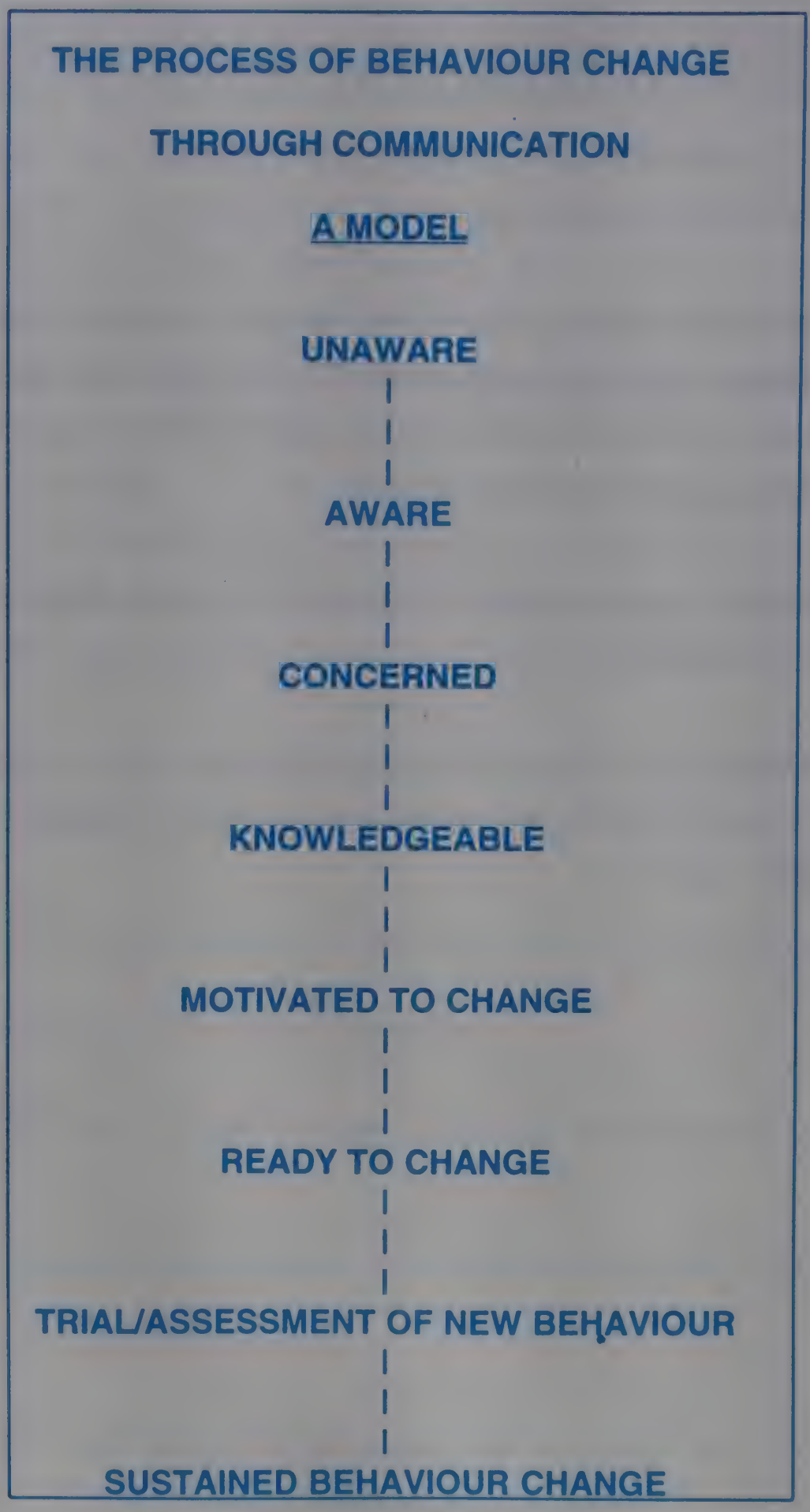
1. Tell the group that many of us have behaviours which we have changed in the recent years or attempted to change and have not been able to change despite trying. These can be related to food habits, dressing, smoking, alcohol, speech habits etc. While attempting to change we all undergo some process and some factors which are responsible for this change.

2. Divide the group into groups of five and ask them to discuss all such incidents/behaviours within the group. After these discussions they are to choose one incident and explain it in detail to the whole group (Allow 20 minutes for discussion). The group should also list out all behaviours that are discussed.

3. After the groups have discussed internally, bring them back and make each group present its discussions.

4. After presentations, use the behaviour change model (slide 1) to explain the process with the help of one of the examples that the groups may have used. An example of smoking is enclosed for reference.

Display the visual below on a transparency or blackboard to explain the objectives of communication and use the following points to elaborate.



Lecture content :

i. Take the example of smoking to illustrate the transparency. People can be educated about the ill effects of smoking on one's own health, those one loves and the world around one. Thus, the **unaware** will become **aware**. This awarness is not adequate if it is not personalised enough to cause **concern**. The combination of awareness and concern make a person **knowledgeable** which can **motivate a person to change**, i.e. to quit smoking or cut down on smoking. A

readiness to change needs to follow, which involves preparedness for coping with the negative effects of a new behaviour. In the case of quitting smoking, it may be ridicule from peers, the possible uneasiness one may experience, the recognition that one may have to replace smoking with a less harmful habit, etc. This stage then leads to a **trial of new behaviour** perhaps with some anxiety about its success. The response to this new behaviour and experiences encountered may (or may not) lead to **sustained behaviour** change.

Merely providing information and theoretical knowledge is thus not enough. A broader attempt has to be made in motivating youth to look at their behaviour and beliefs and in their understanding of the benefits of acceptable alternatives if they are engaged in high-risk behaviour. When this is done in a group setting, the responses of peers also has a strong influencing effect. Young people come to a group with a great deal of information and life experience. They are more motivated to learn, learn faster and think of new ideas if you involve them in a two-way communication process. People find it easier to absorb information and make choices that are right for them if they have the opportunity to talk about their own feelings and ask questions. They can then decide what they most need to know and can make plans to build resources and support that they need."

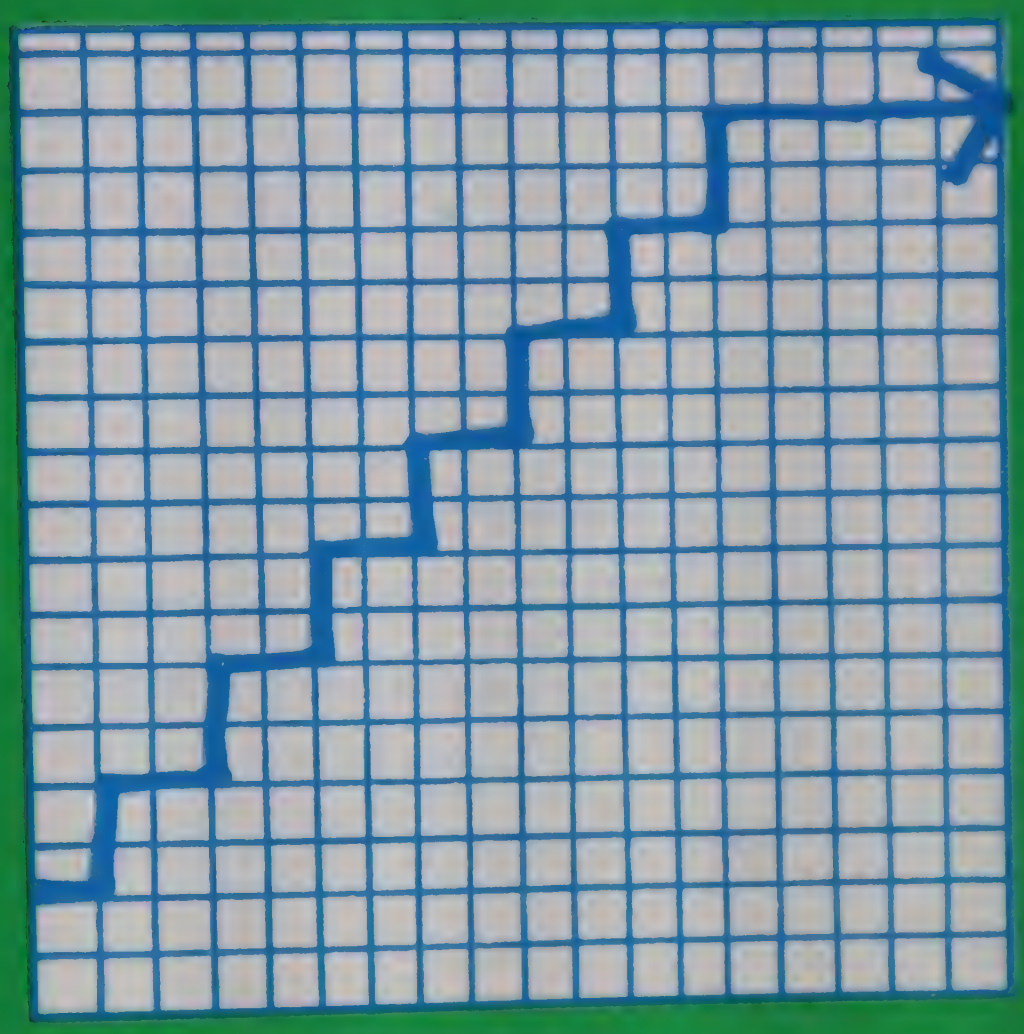
ii. The trainer then takes 5 minutes to talk about different kinds of communication and their effect on the target group.

"Aggressive" Communication: Communicating by forcing your desires or opinions without taking the feelings of others into consideration. Being concerned only with getting your way. Aggressive responses can hurt others' feelings or provoke more aggression. Instead of listening to you, the person may get angry and want to hit out at you.

Passive Communication - Communicating (or **not** communicating) by holding back or playing down your feelings and ideas, so that the other people can get away with anything. Passive responses trust that the situation will turn out okay, or let the other person(s) take all the decisions. If you let this situation happen to you, it may end up with you being ineffective or getting hurt.

Assertive Communication - Communicating by clearly stating your own thoughts and feelings with confidence and showing respect to the person. Being firm and **assertive** is usually the best way to communicate and handle a difficult situation.

TRAINING MODULE VI



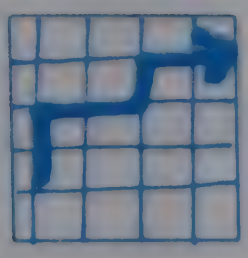
ACTION PLAN DEVELOPMENT

Module VI

Section : 1

CHAPTER 8

Duration: 3 hours 45 minutes
(Including presentation of workplan)



TRAINING MODULE VI
ACTION PLAN DEVELOPMENT

Introduction

This module is to be used for planning HIV/AIDS/STD prevention activities at the university/college level. This exercise should be undertaken by each university coordinator/college programme officer by answering a series of questions, keeping in view the ground realities in their respective work areas.

Each participant will discuss their responses with the facilitator on a one-to-one basis or in groups and thereafter in a plenary session.

Learning Objectives

- To understand the objectives of UTA and the need for planning.
- To formulate strategies related to HIV/AIDS/STD prevention in universities and colleges.
- To devise work plan for the next academic year.
- To clarify the concept of peer education.
- To undertake preparatory work in key planning areas.

Material Needed

Blank sheets of paper, pens, chalk, blackboard/flip chart, OHP

Method

Short Introductory Presentation: Individual work/short group discussion

The facilitator should use the following introductory talk accompanied with slides before the individual work begins.

Introducting the planning function

What is the planning function of management? One way to consider it is: planning is an attempt

to answer questions before they arise, anticipating as many implementation decisions as possible by foreseeing possible problems, and deriving principles and setting rules for solving them. Planning therefore includes the specification of evaluation criteria, rules, norms, etc. that will be used in implementation decisions.

All of you have travelled to reach this workshop. You would have made a series of decisions to do so. They could be:

- destination
- route
- mode of transport, accommodation
- how to avoid or overcome possible obstacles or difficulties
- equipment, clothing
- cost of travel and how much he or she can afford to pay or would be paid
- day-by-day schedule.

Similarly, you as a planner will have to decide on:

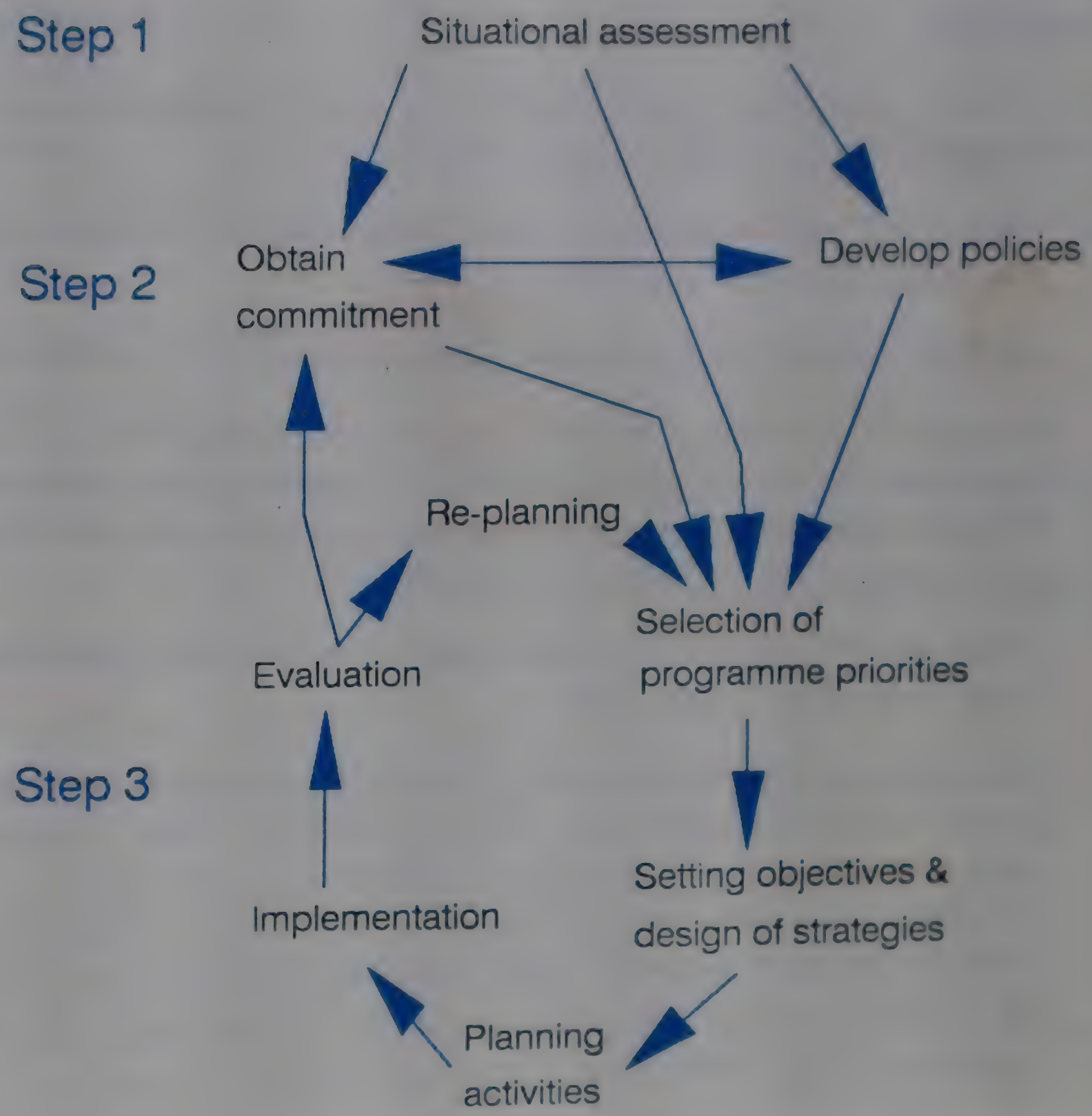
- the objectives of what is being planned
- the approach, or strategy, for reaching the objectives
- the obstacles that may hamper activities
- the resources to be used
- the cost of activities
- the detailed scheduling of implementation.

To determine more precisely the types of decision to be made in each of these areas, it is useful to go through the following questions: why?, what?, which?, where?, how?, how much? and when? and to apply them to the three principal areas of planning, namely:

- objectives
- activities
- resources.

The following steps make it clear that the planning function must be a collective undertaking. No one 'manager' could undertake all the analysis, design and quantification necessary for planning the work of a health team. Realistic planning requires the cooperation of all those who have the necessary information, knowledge and powers of decision. This stresses once again that management is a shared responsibility, and that each member of the team has a share of this responsibility.

MONITORING
RESOURCE MOBILISATION



Steps in programme planning

After the above presentation, start individual work by asking participants to answer the given questions. It is important that you read them out aloud and specify the time frame at the beginning.

The planning exercise is divided into three components :

- Assessment
- Activities implementation
- Monitoring/reporting

Assessment

1. Ask each participant to write down : what is your perception of existing awareness levels about HIV/AIDS/STD in your college ? (allow 3-4 minutes)

2. Where do you think the students have acquired this knowledge from or would acquire this kind of knowledge from? (allow 3-4 minutes)

   After all the participants have answered the questions, the facilitator should state the following:

   It is important to assess the current levels of knowledge at the college/+2 level before initiating any programme. Thus, as a first step of planning, **a rapid assessment needs to be done** to find out the knowledge, attitudes and misconceptions prevailing among students, so that they can be addressed with emphasis in the programme.

   At this point introduce the rapid assessment survey form (See Reference Material : I) and the facilitator should state the following :

   This is a standard questionnaire designed to give you the basic information you will need for planning. You will not be able to survey all the students in your college. So you must select a random sample (say 10 male and female students from each class of 50 and not necessarily NSS volunteers) upto a maximum of 200 students and ask them to fill in the questionnaire. **The students need not fill their name.** These questionnaires should then be analysed with the help of NSS volunteers. Discuss any other point that may be raised by the participants. Findings from this will indicate the quantum of work required.

3. How do you hope to measure the impact of your programme at the end of the academic year? (allow 2 minutes)

   After they write down their responses, the facilitator should state the following: **The questionnaire used initially for assessment could be used after the campaign again.** The

total number of respondents should be more than 200. It is not necessary to administer the questionnaire to the initial 200 people only. You should follow the same random sampling technique used in the first survey.

Activities Implementation (See Reference Material : II)

4. What do you think are the strengths, weaknesses, opportunities, threats in the implementation of this project ?

   (strengths could be management support, strong NSS involvement, easy access to college students, etc.)

   (weaknesses could be lack of commitment, skills, resources, co-educational college etc.)

   (opportunities could be peer group involvement, student need/desire reported in assessment etc.)

   (threats could be parents' displeasure, lack of support from college faculties etc.)

   (allow 7-8 minutes)

   The facilitator may want to pick participants at random and ask them to read out their list and thereafter have a short assessment.

5. What are the needs that are essential for you to conduct the programme at your university/ college?

   (needs could be training, advocacy, IEC materials allow 5-6 minutes.)

6. List down the various activities that you would like to organise at the college level. (allow 4-5 minutes)

   After the participants have written their responses, the facilitator should ask some of the participants to read aloud their list which could be put up on a blackboard/flip chart and the group could be asked to add any additional ones that they think of. Thereafter, emphasise that the participants should plan for activities that they are comfortable with, and at the same time not sacrifice the programme objectives. The facilitator should ensure that peer education is mentioned by the group.

7. Write down what you understand by peer education. (allow 3 minutes) (See Reference Material : III)

   The facilitator should now brain storm the concept of peer education with the help of the slide.

8. With the help of the above, work to make a detailed work plan for the next academic year. List

all the steps that you need to take, chronologically. (allow 20 minutes and refer the sample work plan). (See Reference Material : VIII)

The facilitator should give a sample action plan (See Reference Material : IV) to each participant to use as an example.

Monitoring/Reporting :

After work plans have been discussed, the facilitator should introduce the concept of monitoring and reporting, using the following points. (allow 10 minutes).

9. (a) Monitoring of peer education is a must so that effective checks can be inbuilt in the programme. Peer educators often provide useful insights into the problem which need to be addressed. Each peer educator should have a diary where he/she would record notes of the different sessions they undertake. This should be periodically reviewed by the programme officer

   (b) It is also important to set targets for each peer educator, both qualitatively and quantitatively. (e.g. conduct at least five group discussions in one year (quantitative), produce report on the meetings, discussing problems (qualitative).

   (c) The programme officer should call a meeting of peer educators at least once a month, to discuss the project implementation progress which should focus on problems, new developments etc.

   (d) Each programme officer besides preserving all the raw data, has to send a report to the university coordinator using the following format. (The facilitator should distribute the copies and after the participants have gone through them, a short discussion should be initiated)

Now ask each participants to finalise his plan using the discussion above (20 minutes).

After the participant have finalised their plans, some of them should be asked to present them before the group. Discussions could follow each presentation. Thereafter necessary changes may be made (20 minutes).

At the end of the session, each participant must hand over the work sheets to the facilitator. The facilitator should make a copy for the record and return the copies to the participants with comments if possible. These plans should form a part of the workshop report.

METHOD TO ASSESS THE STUDENTS NEED FOR AIDS EDUCATION A RAPID ASSESSMENT SURVEY

A sample of the target audience is administered a structured questionnaire. It is then analysed to identify the specific needs of the community. The following questionnaire can be used for this purpose for need assessment and evaluation.

UNIVERSITIES TALK AIDS PROJECT

NAME OF THE COLLEGE/SCHOOL : NAME OF THE UNIV. :

Class _____ Sex _____

1. A person can get infected with HIV and not show signs of the disease.

   YES ❑ NO ❑ DON'T KNOW ❑

2. A person can get HIV infection by sharing needles or syringes with someone who has this virus.

   YES ❑ NO ❑ DON'T KNOW ❑

3. A pregnant women who has HIV infection can pass it on to her baby.

   YES ❑ NO ❑ DON'T KNOW ❑

4. HIV and/or AIDS can be cured if detected early.

   YES ❑ NO ❑ DON'T KNOW ❑

5. A person can get the HIV infection by wearing clothes used by someone who has this virus.

   YES ❑ NO ❑ DON'T KNOW ❑

6. When a person has HIV/AIDS, his or her body cannot defend itself from certain diseases.

   YES ❑ NO ❑ DON'T KNOW ❑

7. A person can get the HIV infection by being bitten by a mosquito which has already fed on a person with this virus.

   YES ❑ NO ❑ DON'T KNOW ❑

8. One can tell if the person has the HIV virus by his/her appearance.

YES ❑ NO ❑ DON'T KNOW ❑

9. What is a condom ?

A BARRIER METHOD USED TO PREVENT CONTACT OF SEXUAL FLUIDS ❑
CONTRACEPTIVE TABLET ❑ BALLOON ❑ DON'T KNOW ❑

10. When is a condom used ?

DURING SEXUAL INTERCOURSE ❑ BEFORE SEXUAL INTERCOURSE
❑ AFTER SEXUAL INTERCOURSE

11. Use of a condom during sexual intercourse prevents the spread of HIV through sexual fluids?

YES ❑ NO ❑ DON'T KNOW ❑

12. Having unprotected sex with many partners increases a person's risk of getting infected with the HIV.

YES ❑ NO ❑ DON'T KNOW ❑

13. I worry about getting HIV through blood tranfusion.

YES ❑ NO ❑ DON'T KNOW ❑

14. I worry about getting HIV through indiscriminate use of syringes and needles by the doctors and nurses.

YES ❑ NO ❑ DON'T KNOW ❑

15. I worry about getting HIV through sharing needles with drug users.

YES ❑ NO ❑ DON'T KNOW ❑

16. I worry about acquiring HIV through sexual intercourse.

YES ❑ NO ❑ DON'T KNOW ❑

17. I have difficulty in saying no to my friends when they ask me to do something against my wishes.

YES ❑ NO ❑ DON'T KNOW ❑

18. Young people of my age should be taught to protect themselves against HIV infection.

YES ❑ NO ❑ DON'T KNOW ❑

19. I would rather take the risk of getting HIV/AIDS than miss the chance of having sex with an attractive girl/boy.

YES ❑ NO ❑ DON'T KNOW ❑

20. Some of my friends have had sexual intercourse.

YES ❑ NO ❑ DON'T KNOW ❑

21. My parents would be upset if they found out that I am having pre-marital sex.

YES ❑ NO ❑ DON'T KNOW ❑

22. My parents would be upset if they found out that I am having homo-sex.

YES ❑ NO ❑ DON'T KNOW ❑

23. Some of my friends think that using a condom during sexual intercourse is not enjoyable.

YES ❑ NO ❑ DON'T KNOW ❑

24. It is all right for girls to have sex before marriage.

YES ❑ NO ❑ DON'T KNOW ❑

25. It is all right for boys to have sex before marriage.

YES ❑ NO ❑ DON'T KNOW ❑

26. I can be friendly with someone who has HIV/AIDS.

YES ❑ NO ❑ DON'T KNOW ❑

27. I feel sorry for people who have HIV/AIDS.

YES ❑ NO ❑ DON'T KNOW ❑

28. Other students should be told if a student with the HIV is attending their school/college.

YES ❑ NO ❑ DON'T KNOW ❑

29. I consider abstinence a sure way of avoiding HIV/AIDS

YES ❑ NO ❑ DON'T KNOW ❑

30. Can a person avoid getting AIDS by changing his/her behaviour by doing certain things and not doing other things ?

YES ❑ NO ❑

31. Have you made any changes in your own behaviour or way of life as a result of what you have heard or learnt about AIDS ?

YES ❑ NO ❑

If yes, please specify the changes.

32. Have you had sexual encounter in last six months ?

YES ❑ NO ❑

33. Have you taken any precautionary measures in your last sexual encounter to avoid HIV/ AIDS?

YES ❑ NO ❑

34. If yes, what precautionary measures have you taken ?
Please specify.

35. Which of the following steps do you consider as most effective for students to avoid HIV/ AIDS ?

i. Delaying/postponing first sexual encounter

ii. Using condom

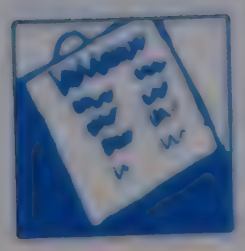
iii. Abstinence

Module : VI

Reference Material : II

Relevant Subsections : IV, V, VI

LIST OF ACTIVITIES



This reference list gives activities that can be conducted in the four major aspects of the UTA project at the institution level.

I. ENVIRONMENT CREATION

Objective: To create a favourable climate for launching the UTA project. As a result of it, students must look forward to the forthcoming activities.

Coverage: These activities must reach out to as many students as possible.

Some examples of activities:

1. Posters announcing the campaign.
2. Posters posing questions on the HIV/AIDS issue.
3. Organise a competition in the college to give an appropriate name to the project.
4. Conduct a survey on students knowledge and attitudes on the issue.
5. Lecture - cum- discussions on the issue with various groups that are likely to be active in the campaign, or can generate the interest of the student community at large.
6. Perform a street play posing the issue, generating interest to know more and announcing the coming campaign.
7. A short session with the other faculties.

II. INTENSIVE AIDS EDUCATION

Objective: To ensure that a package programme primarily on facts relating to AIDS is conducted for the students of the college.

Coverage: All the students, preferably class- wise coverage.

This may be a combination of appropriate methods given below:

1. Peer education: Trained volunteer talking about HIV/AIDS/STDs during the entire period of the year to fellow class mates/college friends.
2. Short presentation.
3. Question-answer (discussion).
4. Screen an audio-visual (subject to the availability of facilities).
5. Conduct a game - high, low or no risk; solve the AIDS puzzle, etc. (adapt for class implementation).
6. Short skit on the immune system, a role play on responsible sexual behaviour could also be built into the package.
7. Give handouts at the end of the session.

Note: Utilise faculty and students for the above, to make it feasible.

III. SUPPORTIVE ACTIVITIES

Some examples of activities are as follows:

1. An exhaustive training programme on the lines given in this module.
2. Panel Discussions.
3. Open Forum.
4. Screening of audio-visual aids.
5. Library (provide reading materials on this subject in the college library).
6. Elocution and essay competitions.
7. Articles in college/school magazine, university diary, etc.
8. Competitions, workshops and/or performance of street plays, folk drama, songs, slogans, etc.
9. Exhibitions.

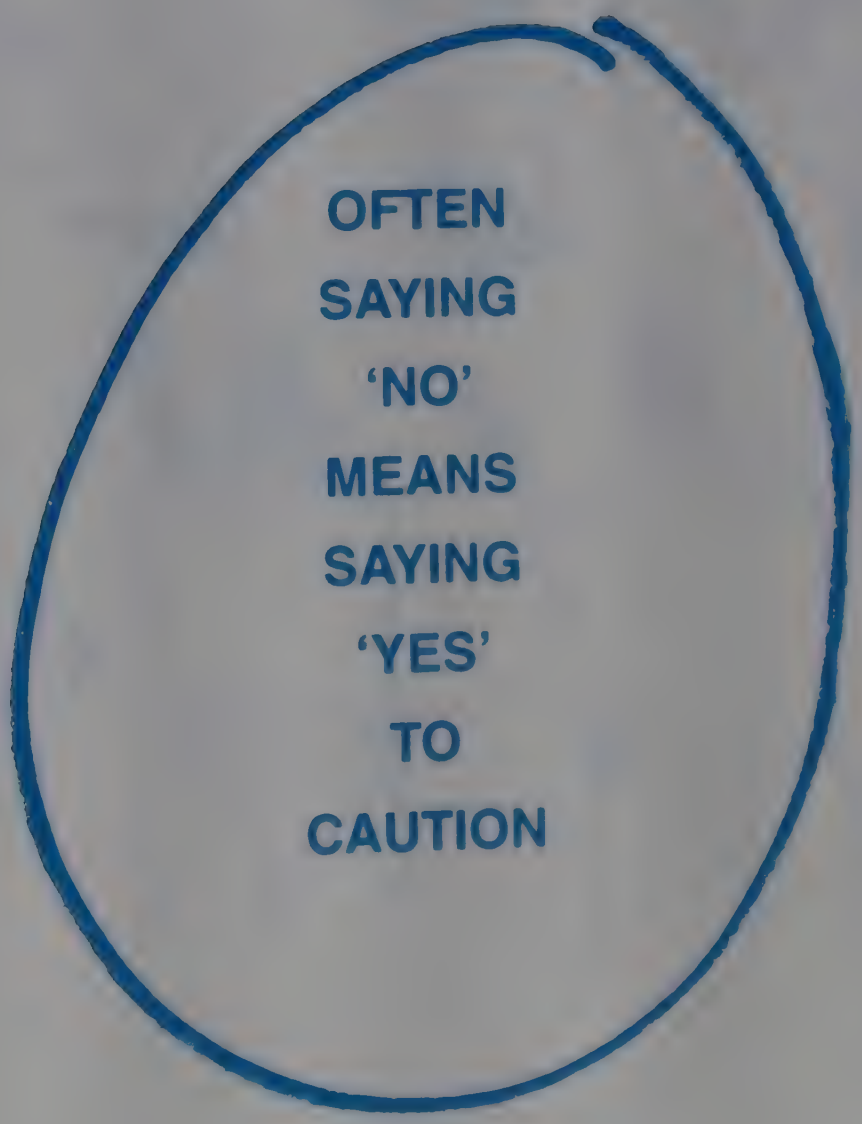
10. Live quiz.

11. Participatory displays.

12. Games, for example, agree/disagree, condom discovery, taking risks and making choices, etc.

13. Audience exercises.

14. Wall panel in college for HIV/AIDS related information



Module : VI

Reference Material : III

Relevant Subsections : VII

HOW DO YOUNG PEOPLE LEARN?

Peer education among the youth means young peers educating their own friends about HIV/AIDS/ STDs.

Module : VI
Reference Material : IV
Relevant Subsection : VIII

SAMPLE WORK PLAN

Subject	1	2	3	4	5	6	7	8	9	10	11	12
(1) Training of NSS Programme officers	X											
(2) Assessment & analysis of college	XX											
(3) Selection of peer educators	XX											
(4) Training of peer educators		XX										
Activities												
(5) Orient staff about UTA programme	XX											
(6) Put up posters on AIDS		XX										
(7) Insert article about AIDS in college magazine			XX									
(8) Organise debate on AIDS							XX					
(9) Organize quiz on HIV/AIDS/ STDs						XX						
(10) Peer education by peer educators			XX								XX	
(11) Other activities specify												
(12) Monitoring			XX								XX	
(13) Post assessment											XX	
(14) Report writing											XX	

UNIVERSITIES TALK AIDS
COLLEGE/+2SCHOOL PROJECT REPORT

Date of Report : Sept/Feb ☐ ☐

(To be submitted to University/+2 Council NSS Programme Coordinator)

* Please enclose copy to Rapid Assessment Survey sheets for further analysis at UTA Cell, New Delhi.

1. State/UT : Code : ☐ ☐

2. University : Code : ☐ ☐

3. College/+2 School (with address) : Code : ☐ ☐ ☐

4. Whether it is coeducational (C) MEN (M), Women (W) : Code : ☐ (C/M/W)

5. Project Officer ☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐

6. Strength of the institution (No. of Students) :

Year of The Course (Graduate/+2 level -as applicable)	Arts		Science		Commerce	
	Male	Female	Male	Female	Male	Female
First Year						
Second Year						
Third Year						
Post Graduates :						
First Year						
Second Year						

7. **Rapid Assessment Survey (RAS) Evaluation :**

(Prior to Project Implementation)

Evaluation Question (Nos. 1 to 35)	Yes	No	Don't Know	Total
Q. No. 1 : Male :	☐☐☐	☐☐☐	☐☐☐	☐☐☐
Female :	☐☐☐	☐☐☐	☐☐☐	☐☐☐

(#) The same pattern is to be adopted for the remaining questions of evaluation/ statements on separate sheets (to find out questionwise response from students).

8. Activities Undertaken :

S.No.	Activity	No. of Students Involved/Oriented		No. of Students Reached/Covered		Duration In Days
		Male	Female	Male	Female	
I.	Peer Educators Training					
II.	Environment Creation a._____ b._____ c._____					
III.	Intensive AIDS Education a. Peer Education b. Other Activities					
	b.1. _____ b.2. _____					

IV.	Supportive Activities (Specify)					

9. **Rapid Assessment Survey (RAS) Evaluation :**
(Post Project Implementation)

Evaluation Question (Nos. 1 to 35)	Yes	No	Don't Know	Total
Q. No. 1 : Male :	☐☐☐	☐☐☐	☐☐☐	☐☐☐
Female :	☐☐☐	☐☐☐	☐☐☐	☐☐☐

(#) The same pattern is to be adopted for the remaining questions of evaluation/statements on separate sheets.

10. What is your overall impression about the campaign undertaken in terms of its need, strategy and adequacy. (Please use additional sheets whenever necessary)

11. Please annexe related materials like photographs, leaflets, literature, video-films, etc. relating to the programme :

List Annexures :

12. Any other information :

Signature
Principal of the College/Institution

Name :

Signature
Programme Officer

Name :

UNIVERSITY/+2 COUNCIL LEVEL

To be submitted to NSS Regional Centre

1. The format is the same as that of the college level, except that number of colleges participating must be specified stating whether the college is of male/female/or co-educational.

2. The University must annexe related material like photographs, scripts, leaflets, charts and posters related to the programme.

3. The University is expected to submit the report of Q.Nos. 1 to 7 by October and for Q.Nos. 8 to 12 by April.

NSS REGIONAL CENTRE LEVEL

To be submitted to UTA Cell, New Delhi

1. The format is the same as of college level, except that number of universities participated must be specified. Specific inputs by the Regional Centres to the programme must be mentioned.

2. Copies of the University reports must also be annexed with the overall report compiled by the Regional Centre.

3. The compiled report should be submitted by the end of April each year. The preliminary report based on the questions 1 to 7 must be submitted in October in the preceding year, alongwith University wise statements.

ANNEXURES

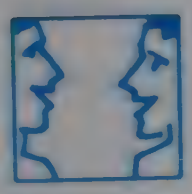
ANNEXURE - 1

ICE BREAKERS AND WARM UPS

Ice breaking and warm up exercises are an integral part of a well-planned training programme. Ice breakers are used in the beginning of a training programme to help the group members become better acquainted with one another and also feel comfortable in each others presence. Warm up exercises are used in the course of training and help to create a pleasant and trusting relationship between members. Essentially both ice breakers and warm ups are community building activities in a group. They are very important in an AIDS training programme, which requires members to feel free to discuss difficult and sensitive subjects together.

For ice breakers and warmups, a room that is large enough to allow unrestricted movement of trainees, is required. Some examples of ice breakers and warmup exercises are given below. Organisers may choose from these. All the warmups given here supplement communication skills.

ICE BREAKERS



1. FINDERS

Time Required: 20 to 25 minutes.

Group Size: Best suited for a group of 15 to 20 members. However, if the group is larger, it may be divided into sub-groups.

Material : A pencil and a copy of Finder sheet (attached herewith).

Procedure:

- The trainer begins by explaining that the group members will be taking part in an exercise that is designed to help them become better acquainted with one another.

2. Next, the group leader gives each participant a pencil and a copy of the Finder's Sheet.

3. The participants are then instructed to stand up, walk around the room and locate, based upon their perceptions or impressions, a person that fits each of the descriptions given in the Finder Sheet.

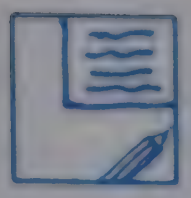
4. At each "finding", the participant introduces himself or herself to that person and explains what description the person fits. For example, "You appear to fit item no.1 on the Finder's Sheet in that you seem to be someone who enjoys children; you have soft, gentle eyes. My name is Sangeeta. What is your name?... Thank you. The participant writes that person's name next to the appropriate description and then moves on to seek another "finding".

5. When the participants have completed their Finder's Sheets, they should introduce themselves to all the other participants they have not as yet met in case there is some spare time.

FINDER'S SHEET

1. Find someone who looks as if he or she enjoys being with teenagers.
   Name :
2. Find someone who seems to be efficient.
   Name :
3. Find someone who looks as if he or she loves animals.
   Name :
4. Find someone who looks as if he or she is ambitious.
   Name :
5. Find someone who looks as if he or she works well with others.
   Name :
6. Find someone who looks as if he or she likes exciting activities.
   Name :
7. Find someone who looks as if he or she is interesting conversationalist.
   Name :
8. Find someone who looks as if he or she would be comfortable using sex-related terms.
   Name :
9. Find someone who looks sophisticated and confident.
   Name :
10. Find someone who looks intelligent.
    Name :

II. COLOUR, CAR, CHARACTER



Duration :15 to 20 minutes.

Group Size: Best suited for a group of 15 to 20 members. If the group is larger, it may be divided into sub-groups.

Material : A piece of paper and pencil for each member.

Procedure:

1. While distributing paper and pencils to all the participants, the trainer explains that the group members will be taking part in an activity that is designed to help them become acquainted with one another.

2. The group leader then asks that each participant to write his or her name on the piece of paper. Under his or her name each participant is to write a colour which he or she feels fits his or her personality. Beneath the colour the participant is to write an issue he/she feels strongly about.

3. Then, one at a time, the group members introduce themselves by stating their names, colours, and the issue that moves them. In the introduction each participant is to provide a brief rationale for each of his or her two choices. For example "I see myself as the colour yellow. I am cheerful and love outdoor activities."

4. The exercise continues until all of the participants have introduced themselves by colour, name and their issue or value.

Variations

- If the group contains more than 20 participants the trainer may ask the group members to give only one description of themselves, such as their relation to a particular colour, car, or character.

- The group leader may request that the participants relate themselves to various kinds of insects, flowers, foods, games, film stars, political figures, or any combination of these.

- The trainer may ask that each participant give his or her name and then acts out one or all of the chosen descriptions while the other group members attempt to guess the particular colour, car or fictional character he or she has selected.

III. THE NAME GAME

Duration: 15 to 20 minutes depending on the size of the group.

Group Size: Best suited for a group of 15 to 20 persons. For a larger group, divide into sub-groups.

Material : A piece of paper and pencil for each member.

Procedure:

1. Have the group sit in a circle. Start with yourself as group leader and write your name on a large piece of paper. You could also say what your name means or any story associated with it, e.g., "My name is Sundernarayan and I was named after my father."

2. The next person writes his/ her name on the piece of paper. He/ she also adds a story associated with his/her name.

3. Each person in turn writes his/her name and tells his/her name's story. The paper is then attached to the wall for the duration of the session.

Variation

You can also ask group members to tell their names and related stories without writing them. Each person has to try to remember all the names that went before him or her. This provides a way to do the activity without having to write anything and may be helpful if some of your members do not write well.

IV. DIADS

Duration: 20 minutes.

Group Size: Best suited for 20 - 25 members. Can be used with larger groups, but should then be used in combination with other ice breakers.

Material : None.

Procedure:

1. Group members are asked to pair up with each other, whom they may not know, they are told to talk to each other so as to be able to know each other adequately enough to introduce his/ her partner.

2. After 5 minutes announce that 2 pairs must come together and each one must introduce their partner, not themselves.

3. After 10 minutes announce that 4 pairs must come together and talk on any subject they would like to for the next 5 minutes.

V. THE LABEL GAME

Duration : 20 minutes, could vary with group size.

Material : Paper 3" x 4" as badge, a pin and pencil for each group member.

Group Size : Any size.

Procedure :

1. Give a badge, pin and pencil to each member.

2. Ask them to write their name, likes and dislikes, on the badge.

3. They must then wear the label and move around, mixing with new partners each time. The label helps to initiate a conversation between partners.

Variation

THE LABEL MARCH. Additional material required - music tape and player.

Procedure

1. After the members have written the necessary information on their label they form two concentric circles. Both circles should have equal numbers.

2. With the start of music the inner circle moves anti- clock wise.

3. As soon as the music stops the partners opposite each other in the inner and outer circle talk to each other. The matter on the label helps to start the conversation.

WARM UPS

I. LISTENING AND ATTENDING

Specific Objectives

1. To appreciate the skills of genuine attending.

2. To gain rudimentary skills in the use and practice of attending.

Materials Needed : None.

Group Size : Unlimited.

Duration : 25 minutes.

Method

1. The trainer asks participants to choose a partner.

2. They are then instructed to think of a current personal problem or concern that they are willing to discuss. Then, they are told that each partner will have 5 minutes to talk about his or her problem, during which time the other person will listen attentively and communicate empathy and understanding non-verbally. The listener should not speak at all.

3. After five minutes, the trainer asks the pairs to stop and switch roles, whereby the listener now becomes the talker.

4. After each of them has spoken for 5 minutes,the trainer asks the pair to discuss their experience for 3-4 minutes.

5. The trainer then reassembles the complete group and begins a general discussion of the activity around the following questions -

- ❑ How did you feel about talking for 5 minutes without interruption?
- ❑ How did you feel, listening but not speaking?
- ❑ Did you feel your partner was (or was not) listening attentively? What non-verbal cues gave you this indication?
- ❑ Did you feel that your partner understood your problem? How could you tell?

6. In conclusion, the trainer can offer the following tips to the participants on good listening:

(a) Good attentive behaviour demonstrates to others that you respect them as people and that you are interested in what they have to say, e.g. turning towards the person, nodding where appropriate ,etc.

(b) Use eye contact by looking at the person with whom you are talking.Vary your gaze rather than staring fixedly.

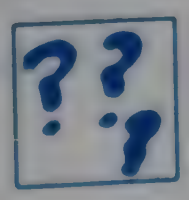
(c) Do not talk or interrupt. One cannot listen if one is talking.

(d) Remove distractions. Do not doodle, tap or vigorously shake your head. Reduce noise disturbances from outside if possible.

(e) Empathise with the other person. Try to put yourself in his/her place so that you can see his/her point of view.

(f) Try to avoid criticism or argument in your responses. This only puts the other person on the defensive.

II. ASKING QUESTIONS



Specific Objectives

1. To appreciate the use of questions in promoting a two-way active communication between the group and the speaker.

2. To see the benefits of asking open-ended questions, at appropriate moments.

3. To practice asking open-ended questions.

Material Needed: None.

Group Size: Unlimited.

Duration : 35 minutes.

Method

1. The trainer divides the group into sub-groups of three people.

2. The trainer requests each triad to choose and determine roles for themselves: speaker, listener, observer. Each member of the group will play each role.

3. The trainer asks the "speakers" to think of a current personal issue or problem that they are willing to discuss.

   The speaker speaks for 5 minutes on the issue. The listener can only respond with questions. The observer has to write down the questions the listener asks, noting whether they are open-ended or closed, "yes", "no" questions.

4. When 5 minutes are over, the trainer asks the triads to discuss, for 2 minutes, what type of questions were used in the role play and whether or not they were effective from each person's perspective.

5. Then, the triad switches the roles and repeats this process two more times so that each person gets to play all three roles.

6. The triads are then reassembled as full group by the trainer and the exercise is discussed, using the following guiding questions:

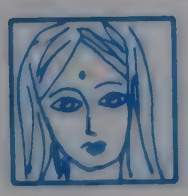
   - As speaker, what was it like to be asked closed and open-ended questions?
   - As listener, what was it like to ask closed and open-ended questions?

- ❑ In what instances were closed questions most helpful? Least helpful?
- ❑ In what ways are open-ended questions effective when encouraging group discussions? When are they not appropriate?

Brief Note for Trainer

Closed questions are those where the questioner has a specific agenda in mind and methodically leads the participants to the topic of interest. They are specific in the response they seek and very often end up with "yes" - "no" answers. They also take the form of multiple-choice questions. Some examples are, "Are you married"? "Do you get along with your wife?" Open ended questions provide room for the person to express himself/herself without any imposed categories. The questions are centred around the respondent's concerns and help him/her to clarify his/her own problems. Some examples, "Could you tell me a little about your marriage?" "How did you feel when your friends teased you about your boyfriend?" Close ended questions, however, have a place initially as they provide a structure to the person who is diffident to provide information, and to get a person back on track, if he/she is rambling or losing focus.

III. THE LOOK



Specific Objectives

1. To increase one's sensitivity about how other people perceive one's posture and facial expressions.

2. To practice the art of being able to assume various postures.

3. To learn to communicate one's emotions by using body language.

Group Size: Unlimited.

Duration: Approximately 10 minutes.

Materials Needed

The "Sample Postures" list that has been prepared in advance for the trainer.

Method

1. The trainer begins the exercise by explaining that the participants will be using facial expressions and body movements to imitate or emulate specific attitudes/feelings/emotions. The trainer may model a look (such as "I don't care" look) for the group members.

2. Next, the participants are instructed to stand up and start walking around the room. The trainer explains that when he or she calls out a "specific look" (from the Sample Postures List given below), the participants are to stand still wherever they are and use facial expressions and body movement to capture or represent the given "look".

3. The trainer reads the first item on the list, allowing the participants 20 seconds to emulate the "look". They then mill around the room some more until the trainer reads the second item when again the group members freeze and emulate the look for 20 seconds.

4. This process is repeated for all the "looks" on the list.

5. Once the list is exhausted, the trainer concludes the exercise with a discussion in which the participants are encouraged to share what each posture conveyed to them, how other people's look affected them, how this is true in real life too and how each part of the body is important in conveying a certain attitude or mood.

6. "Sample Postures" List -

- "I am bored" look.
- "You are stupid and I am intelligent" look.
- "I just got promoted" look.
- "I have too much to do" look.
- " I am very excited today" look.
- "I like myself and I like you" look.
- "I am worried" look.
- 'I am very angry with you" look.

IV. SCULPTING FEELINGS

Specific Objectives

1. To be able to identify a range of feelings.

2. To be able to demonstrate feelings non-verbally.

3. To enhance one's skills of recognising feelings from non-verbal cues.

Material Needed : Blackboard, chalk.

Group Size : Unlimited.

Duration : Approx. 25 minutes.

Method

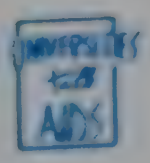
1. The trainer asks the full group to brainstorm a list of feelings or emotions, calling them out by name. The trainer writes each word on the blackboard.

2. The trainer divides the group into small groups of 6-8 people. He/she then asks each participant to choose an emotion from the list on the board and, taking turns, act it out for the others in the group without using any words. The other group members have to guess which emotion is being portrayed. The group can make only three guesses. Each enactment gets about 3-5 minutes after which the next group member enacts his/her chosen emotion.

3. Once all the small groups have completed the list at least once or when 20 minutes are over, the trainer re-assembles the whole group and does a brief processing of the activity.

Discussion Points to be Emphasised

- Which non-verbal cues were most helpful in communicating the emotion?
- Were some feelings easier to guess than others? Why?
- Which non-verbal cues were misinterpreted or missed when the wrong emotion was guessed?



V. FISHBOWL FOR VERBAL AND NON-VERBAL COMMUNICATION

Specific Objectives :

1. To practice verbal and non-verbal communication skills.

2. To receive feedback on one's overall communication style.

3. To identify gaps in knowledge or areas related to communication where confidence is lacking.

Material Needed : "Scenario" statements photocopied and cut out for half the total number of participants.

Group Size : Not more than 40 participants.

Duration : Approx. 1 hour.

Method

1. The trainer divides the group into two equal halves. The first half then form a circle in the middle of the room, facing outwards (i.e. away from each other). The second half should form a larger circle around them, facing inwards (towards the inner circle), so that each person is facing and standing opposite a partner.

2. The trainer instructs the members of the outer circle to introduce themselves and say the following sentences to their partner of the inner circle, "I am here today to tell you some facts about AIDS and HIV transmission. Do you know anything about HIV or how it is transmitted? Where would you like me to begin?" Their partners in the inside circle are to act as "target audience" and respond to the questions of the communicator. The communicator then talks on the requested subject for 3 minutes.

3. After 3 minutes, the trainer instructs each outer circle person to move to the person on their left and repeat their opening lines, until each person of the inner circle has heard them. The "communicator" can vary his/her opening lines vis-a- vis tone and words but should convey the same essence basically.

4. Then the trainer asks the two groups to change places and the former "communicators" now get a "Scenario" card which they read aloud to the person facing them, who must now speak for 3 minutes on the issues. His response must convey understanding, information and interest.

5. The outer circle now repeats the same process the previous outer circle had done, in terms of moving on to the person on their left after 3 minutes, listening to the new scenario card and responding. Since only 10 scenario statements are given below, these may be repeated if the group is larger so that two people would have the same scenario.

6. When this second round is over, the trainer reassembles the full group and starts a discussion by asking the first inner circle which style of introduction the listeners liked best and why. He/she also asks the first set of "communicators" how they felt the first few times as compared to the time they had finished introducing themselves to the entire inner circle. The other questions to be touched upon in the discussion are: for the scenario statements, what responses were the most helpful and positive? Why? Did the verbal and non-verbal responses of "respondents" match?

7. ***Scenario statements cards :***
(to be read out aloud by the participant as they appear on the card).

i. What exactly is safer sex?

ii. How do you use a condom?

iii. What other kinds of sex are there apart from penetrative sex?

iv. I'm on smack and I inject it. How can I be sure the needle I use is clean?

v. How can a woman give me the virus? (a male asking this)

vi. I don't know how to tell my girlfriend I've got this virus.

vii. I used to take heroin a few years ago. Should I have a test?

viii. I'm a call girl and sometimes my clients won't use condoms. Should I have a test?

ix. How do I know blood donating won't lead to my getting infected?

x. I think my husband is bisexual.

xi. I think my wife is bisexual.

ANNEXURE -2

WOMEN AND AIDS

Introduction

AIDS was first discovered among homosexual men in the United States. Till some years later it was considered to be a disease that affected only men. Now, in the 1990's it is becoming increasingly clear that AIDS is a disease which will have a major impact on women and children.

In Africa, half of all HIV infections are among women and children; infant mortality rates are increasing rapidly due to the number of children born with AIDS. AIDS will single handedly wipe out all the advances made to date on maternal and child health, and by the year 2000, WHO estimates that there will be 10 million uninfected orphans whose parents have died of AIDS. India is following many of the patterns existing in Africa.

AIDS affects women not only as individuals, but also as health care providers, educators, wives, mothers and income providers. It is not only the infected women who are affected but also the women suffering from the economic and social consequences of the disease.
The following outlines the major issues related to Women and AIDS.

Risks for Women

Biologically more vulnerable : Women are biologically at a greater risk than men - it now appears that male to female transmission is 2-4 times as efficient as female to male transmission, while, with other STDs male to female transmission is at least 15% more efficient than female to male transmission.

STDs not diagnosed or treated : Many women suffer from asymptomatic STDs or have symptomatic STDs which are not diagnosed or treated. In addition women have a limited access to STDs treatment facilities and health care in general. Should a woman go to an STDs clinic, she is often considered a sex worker.

Use of non-barrier methods of contraception : Women use contraceptives without accurate knowledge of its relationship to HIV infection. Use of IUDs or heavy use of viricide could put a

women at greater risk, while use of other contraceptives such as the pill, injectables and implants discourages the use of condoms.

Receive unnecessary blood transfusions : Women often receive blood transfusions related to child birth or anemia, often unnecessarily.

Traditional practices : Traditional practices such as female circumcision, tattooing, etc. could place women at risk.

Other risks for women

Women are at risk for HIV infection and other STDs just like men if they have multiple partners, and inject drug. But women are also at a risk of contracting the HIV infection from coercive sex, due to their economic status which force many women into selling sex for money. In addition, many women are at risk of HIV infection from their partners. One estimate claims that, every day 1500 women become infected with HIV and their only risk behaviour is having sex with their husbands.

Women's ability to protect themselves - (negative factors)

In addition to being more vulnerable to the HIV infection, women have limited ability to protect themselves. Some factors which contribute to this reality are :

- Lack of economic alternatives.
- Lower literacy levels.
- Limited mobility.
- Limited access to information.
- Limited access to appropriate STDs services and other health services.
- Attitudes towards sexuality - women are traditionally the passive, submissive partner in sexual relations. Women are not told the basic facts about sex. Very often a majority of women are subjected to sexual relation in order that they may conceive a male child. This enhances their chances of getting infected by the HIV virus.
- Psycho-social, cultural and legal barriers to women's decision making powers and independence — even if a woman knows about HIV and how to protect herself, it is not always possible for her to refrain from sex with her husband if she feels he is unfaithful or convince her husband to use a condom. Even in the most progressive western

relationship, asking a husband to use a condom is a topic many women hesitate bring up. Should a woman have an STD, the psycho-social and cultural condemnation is so great, that visiting a reputable STDs clinic is often ruled out in favour of self-medication.

All these issues are related to the status of women in society. The lower status women have in society, inhibits their ability to protect themselves against HIV infection. The AIDS epidemic will only exacerbate these problems as scarce resources are given away to medical treatment and a substantial slice of family income is expended on illness.

Impact on women

The AIDS epidemic will have not only a physical impact on women, but also affect the many roles they play in society.

- **Caretakers** - women have traditionally been the caretakers. As the epidemic takes its toll, this will increasingly take women away from duties as a parent, and a productive individual and towards the community. The impact of this in terms of agriculture, child health, and social structures will be enormous and is now being studied.
- **Wives** - they will be affected in their role as wives when they are confronted with transmission of HIV by their husbands.
- **Mothers** - Physically and emotionally women want to bear children. If the woman is HIV + and also pregnant, she is in dilemma. 20 - 30% of all children born from an HIV + mother will be "AIDS Babies", the remaining 80% will become AIDS orphans as the mother eventually dies of AIDS.
- **Economically,** women will be adversely affected as their scarce resources are spent in the treatment of a terminally ill family member.
- The **social impact** in terms of discrimination will be severe. Today in the developing world, including India and Thailand, commercial sex workers are being blamed for spreading the disease. Women who give birth to HIV + children are blamed. Women in many parts of the world are disowned by their families if they are HIV + and deprived of their rights. Discrimination against HIV + men also takes place, but men have more legal accessibility in comparison to women.

Women play an important role in development and carry many burdens. These burdens will be increased dramatically due to the epidemic and will adversely affect their role in the development effort.

Action for women and AIDS

In order to mitigate the consequences of the AIDS epidemic on women, it is necessary to take steps to get a grip on the situation.

- Women's groups need to be oriented and mobilized.
- Research on women in relation to the AIDS epidemic needs to take place.
- Alternative methods of protection which are in the hands of women need to be further developed and refined, such as the female condom and viricide.
- Information, education and communication strategies and materials need to be developed which can reach women in a manner and form which they understand.
- Women need assistance in building skills on negotiating sexuality.
- Sex education, both physiological and psycho-social, for both boys and girls needs to be an integral part of school curriculum.
- STDs services need to be integrated into MCH/FP clinics and other health services.
- Government and NGOs need to evolve support services in the areas of counselling and care to assist in women's increased burdens due to the AIDS epidemic.

The AIDS epidemic can also be viewed as an opportunity to focus innovative strategies and resources into the issues surrounding the status of women while tackling the pressing issues raised by the AIDS epidemic.

Conclusion

AIDS raises many issues that the majority of people would rather see left in the closet. AIDS is an issue where the boundaries of cultural sensitivities must be stretched. It will force people to openly discuss sexual relations; promote sexuality education in the schools for both girls and boys; and create a climate where parents feel free to discuss aspects of growth including sex and sexuality. AIDS is an issue which can be used to empower women to become more assertive and equal sexual partners.

Actions to address the issues related to women and AIDS should be integrated into all schemes addressing women and development.

Dealing with the issues surrounding women and AIDS is the responsibility of both men and women. Men have to show a greater understanding towards the needs of women. Work on a common goal for women and AIDS by men and women will have a positive impact for the community as a whole.

ANNEXURE - 3

POPULATION EDUCATION AND AIDS

The youth is the most productive and reproductive segment of the population. Although the fertility rate is the highest in the age group of 15-29 years many young people are not scientifically aware of the reproductive process. They need information and guidance on this from various sources : teachers, parents, peers and the society. Adolescent attitudes, values and knowledge about marriage, family, heterosexual relationships, anatomy, reproduction and planned parenthood are critical factors influencing their demographic behaviour.

Education of AIDS is specially relevant in this context as it not only deals with sex and sexuality but also makes the younger generation aware of self protection, personal hygiene and healthy life style as unwanted pregnancies and abortions are steadily increasing among the youth. There is non awareness about contraception. Therefore it is necessary to educate them about protection and prevention method.

The arrival of AIDS in India has complicated the issue further. There exists a lot of confusion about contraception against pregnancy and protection against HIV/AIDS. Some people may not be aware because of taboos, fear, ignorance that the only method to avoid HIV/AIDS/STDs as well as unwanted pregnancy is the usage of condom. As the pressure of the ever-increasing population-wipes out new opportunities for youth, so also AIDS has the potential to wipe out the youth itself. Thus, the young people are at stake in both situations. For many this is a matter of personal decision making. Exercising the right choice and making appropriate decisions is very important in this matter as there is still some ambiguity about contraception and prevention of AIDS. It is felt necessary is clarify the confusion by providing a brief description about various contraceptives.

Copper-T

It is an intra-uterine device shaped like the alphabet 'T' and is moulded from polyethylene. The device has a coil of fine pure Copper wire wrapped around its vertical arm. It exerts anti-fertility effects by the presence of copper. It changes the composition of the secretion in the uterus and prevents fertilization of egg in women.

Benefits :

It is a safe, reliable and harmless method of a avoiding pregnancy and of spacing births. Its insertion does not lead to any complication. It is a convenient method of spacing with a three year interval.

Side effects : Some women may have some side effects at the initial stage which are as follows-

1. Slight pain or cramps in the abdomen for the first few days.

2. Increased menstrual flow a few a few months.

3. Slight bleeding for a week.

'Pill', The oral method

'Mala D' and Mala N are contraceptive pills. These are easy, safe, effective and reversible contraceptive for women wanting to delay the first pregnancy or space the next child. These pills work by suppressing the release of the ovum (egg cell) from the ovaries.

Benefits :

1. Eases pain during menstruation.

2. Reduces excessive bleeding during menstruation.

3. Provides some protection against pelvic infection.

4. Protects against - benign breast tumours and ovarian cysts.

Side effects :- There may be some discomfort such as tenderness of breasts, headache or nausea in the first one or two months. But these symptoms disappear very soon.

In some women long term use of oral pill may lead to increased risk of high blood pressure, heart-attacks etc.

Nirodh:

Nirodh is a condom. It is a fine rubber sheath which is used by men during then sexual act. It prevents pregnancy by covering the male organ and preventing the male sperms from reaching the ovaries. Nirodh is available in four varieties :

Normal, New Increased Nirodh, deluxe Nirodh, and super deluxe Nirodh.

Nirodh is a fool proof method of avoiding a pregnancy if used properly. It does not have any ill-effects or side-effects.

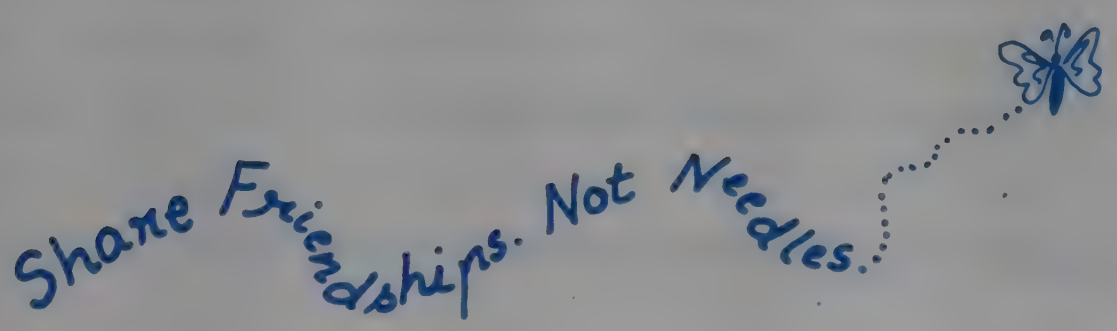
Nirodh has to be used for each and every sexual intercourse to avoid unwanted pregnancy.

Injectable Norethisterone Enanthats

Net-EN, 200 mg given every two months is a spacing method. It is administered as an intra-muscular injection.

Side effects - Menstrual changes occur in the majority of women using this method. Amenorrhoea or cessation of menstrual flow occurs less frequently women using Net-EN. Headache, dizziness, weight gain and mood changes are common in women.

It has not been introduced yet in the National Family Welfare programme.



ANNEXURE - 4

LIFESTYLE EDUCATION FOR YOUTH

- Man today is viewed as an 'agent' of his own diseases. The medical world has now recognised the significance of lifestyle in causing and contributing to many illness of youth and adults.

- Lifestyle denotes a close link between the living conditions of an individual, his or her activities and socially formed strategies for coping with life.

- There are also a number of factors related to **belief**s that influence change in behaviour and risk-taking patterns. It depends upon (i) how the youth perceive the seriousness of the problem, (ii) what is their feeling of personal vulnerability, (iii) what are the personal benefits of taking preventive action and (iv) what is the personal cost of taking such actions.

- Some lifestyles are self-destructive and others are health-promoting. A careful selection and popularisation of the health - promoting lifestyles would encourage the youth to adopt these to their advantage.

- People planning life style education centres and educational programmes for the young must recognize that risky behaviour is a natural part of growing up. The risk behaviour - involves, only a short - term, time perspective.

- But, more than any other age-group, young people, particularly adolescents are the most vulnerable because of their risk-taking behaviour.

- For instance, the average age of drug users is declining all over the world. In India, most of the injecting drug users are youth, who get HIV infection through it.

- Next to war and malnutrition, alcoholism has emerged as the most devastating socio-medical problem faced by human society. It exposes youth to aggression, accident, suicidal behaviour and risky sexual practices.

- Smoking, to which many young people are attracted, has become a great killer habit.

- In addition to drugs, tobacco and alcohol, risk-taking experimentation in sex has steadily exposed the youth to HIV/AIDS and sexually transmitted diseases.

- The majority of STDs that occur in the world are in the age group of 15-24 years.

- Most of the health problems of the adult and the aged are in fact consequences of risk-taking behaviour.

- The socialising role of the family, friends and peers is steadily disappearing compounded by the indifference of the educational institutions in dealing with the problems of growing-up. Many families and schools do not have either experience or information to guide the student-youth. This emphasises the need for guidance in lifestyle and lifeskills to reduce anxiety, stress, frustration, insecurity and high-risk behaviour.

- Young people who have never or rarely experienced or witnessed serious ill-health due to their age may not appear to be concerned about the effects of ill-health at a personal level and are unlikely to see them seriously. This is the real challenge for the life-style trainers and facilitators.

- Intervention strategies need to be designed to mould the life-style of youth. The most important strategy is to inspire young people to place a value on health. Information and education will, no doubt, form an important component of these strategies. Another important strategy would be to inspire young people to become their advocates of own health.

- But giving the youth knowledge alone will not change their habits. A participatory health education through peers does provide the young people an opportunity to identify their own concerns through self examination of values.

SOURCES AND REFERENCES

CHAPTER 4

Source : Adapted from **Action on AIDS** and edited by Dr. C.J. Van Dam, STD Adviser, Global Programme on AIDS, India, World Health Organisation.

REFERENCES

1. *Life Planning Education : A Youth Development Programme*, The Centre for Population Options, Washington, D.C., 1985.
2. *"I Am Joe's Body"*, J.D. Radcliff, Readers Digest Edition, 198
3. *Our Bodies, Our Selves :A Health Book by and for Women*, Phillips Angela & Jill Rakusen,Penguin Books, 1979
4. *Teenagers Ask : The Doctor Answers*, Dr. M.C. Watsa, FPAI, Bombay.
5. *Do You Know ? A Guide to Teenagers*, B. Krishna Rao, Academic Books, Delhi/Bombay, 1992
6. *Common Sexual Problems .... Solutions*, Prakash Kothari, Ved Publishers, 1987.
7. National Workshop on Youth Action on AIDS, Commonwealth Youth Programme, Asia Centre, Chandigarh.

CHAPTER 5

Source :
Adapted from Hilary Dixon and Peter Gordon, *Working with Uncertainty*, 1987. Peter Aggleton et. al., *AIDS : Working with Young People*, AVERT, 1990. UCSF Center for AIDS Prevention, SPUSD Health Programme and SFUSD Peer Resource Programme, *Healthy San Francisco Teens*, 1990.
Source Adapted from :

1. *AVERT Manual* by Peter Aggleton, et al.
2. HIV and Development Workshop (UNDP) notes.

Source of Scenarios:
Pragnya : From Consciousness to Awareness by Rashmi Pachauri Rajan , Documentation of the AIDS Resource Group of Madras Medical College, Madras, 1992.
Source:
Guidelines For Counselling About HIV Infection and Disease WHO AIDS Series 8, Geneva : WHO 1990, pp. 27-30.
Source :
Guidelines For Counselling About HIV Infection and Disease WHO AIDS Series 8, Geneva : WHO 1990, pp. 12-13.

LIST OF RESOURCES

1. *Action for Youth : AIDS Training Manual* - League of Red Cross and Red Crescent Societies and World Organisation of the Scouts Movement.
2. *Talking AIDS* by IPPF.
3. *Challenges of AIDS* by Dr. Khorshed Pavri.
4. *AIDS Prevention in India : the Socio-Cultural Context*, Purnima Mane and Shubhada Maitra, Bombay:TISS,1992.

CHAPTER 6

Note Prepared with the help of :

1. Hubbard, Betty, M. Preventing Sexually Related Disease, *Contemporary Health Series*, Entering Adulthood, Calif, USA, ETR Associates, 1989.
2. *Action for Youth: AIDS Training Manual*, Geneva: League of Red Cross and Red Crescent Societies, 1990.
3. *Healthy San Francisco Teens*, 1992, Calif: UCSF, SFUSD.

Source
Adapted from : *Healthy S.F.Teens* (Referred to earlier).
: *AIDS Working with Young People* (Referred to earlier)

Source
Activities adapted from :
Girls Incorporated : *Keeping Healthy Keeping Safe: HIV Prevention and Education Program*, 1992.
Source :
Adapted from : *Healthy San Francisco Teens*
Source
Healthy S.F. Teens.
Resource Kit:

1. Flier on condom use (pictorial) Do's and Don'ts from Manual of GPA WHO .
2. Note to facilitator on barriers to condom use (attached).

Source :
Mane,P.and Maitra, S. : *AIDS : Prevention: The Socio-cultural Context in India*, Bombay : TISS, 1992, pp.98-110.

Taken from *Midlife, Family and Community health Through Care giving*, Newton, M.A. : Education Development Centre, 1981, pp. 14-15.

CHAPTER 8

Reference
AIDS awareness campaign, Hyderabad Experience.

ANNEXURES

Sources/References

1. Healthy life style, TISS.
2. Pamphletes of Family Planning Association of India.

OTHER REFERENCES AND RESOURCES

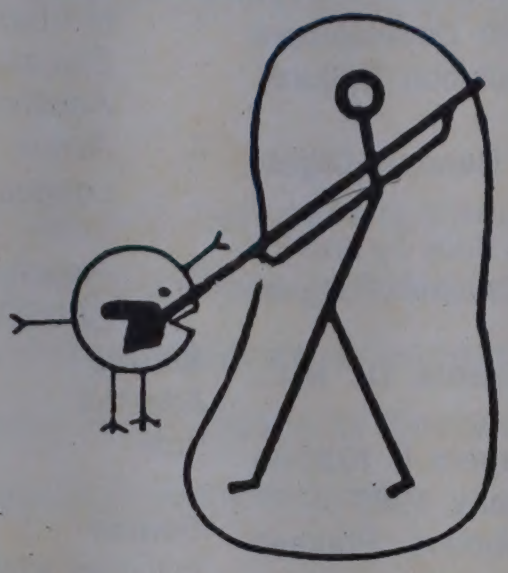
3. Paraguya, AIDS Resource Groups of Madras Medical College, Madras.
5. Student youth and sexuality - A paper presented by Dr. Bhagbanprakash in Berlin.
3. Youth Action on AIDS - An Indian Report presented by Mr. S.K. Sawhney at Kualalampur, Malaysia.

HOW HIV WEAKENS THE IMMUNE SYSTEM

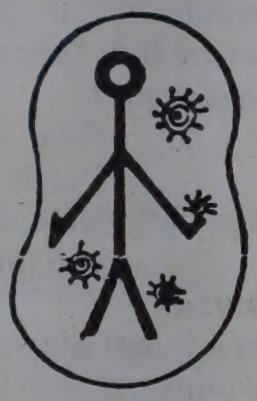
WHITE CELL

BODY SOLDIER

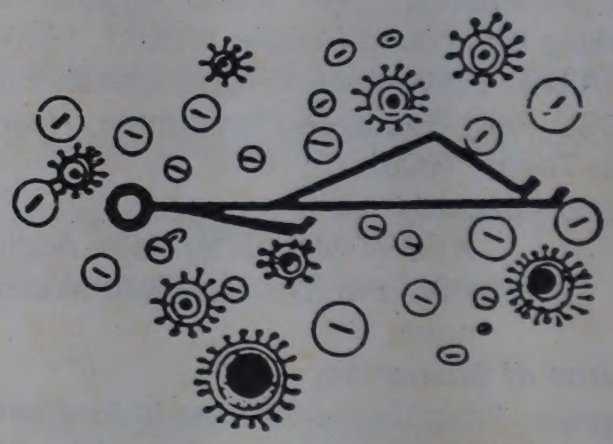
BODY SOLDIER KILLS GERMS THAT ATTACK THE BODY.



UNPROTECTED SEX OR INFECTED BLOOD OR SHARING INFECTED NEEDLES SEND HIV INTO THE BLOOD STREAM.

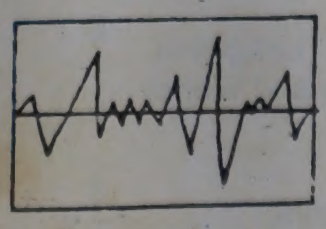


HIV VIRUS ATTACKS BODY CELL.
1000s MORE SOLDIER CELLS GET INFECTED.



BODY SOLDIER DIES.
OTHER GERMS INVADE BODY.

NO MORE SOLDIERS TO KILL GERMS.
BODY SERIOUSLY INFECTED.



HOSPITAL TREATMENT NEEDED.

UNTIL THE NEXT GERM ARRIVES....

Getting their kicks from chastity

By David Usborne

WASHINGTON: There is a new buzzword beginning to travel the classrooms and recreation yards of America and it has nothing to do with records or airlines. It is "virgin", as in "I'm gonna stay a...". The movement is still small, but its momentum is evidently growing.

"Virgin clubs" are being formed in schools around the country and purity before marriage has become the topic of magazine and television features. Twenty-five years after Woodstock, it is the new counter-culture.

Its strength was on display in Washington two weekends ago when followers of "True Love Waits,,' a church-based campaign dedicated to promoting sexual abstinence, descended on the Mall in front of Congress and staked into the turf more than 200,000 white pledge-cards, each one signed by a young person swearing off intercourse until marriage. The few words on the cards are bland enough, but radical "Believing that true love waits, I make a commitment to God, myself, my family, those I date, my future mate, and my future children to be sexually pure until the day I enter a covenant marriage relationship."

The Rev Richards Ross, a Baptist minister from Nashville, Tennessee, founded True Love Waits early last year. He is not surprised by its success. "All many teenagers wanted was a clear, positive call to abstinence," he said in an interview. "We have become so wrapped up in condoms and pregnancy that the only message teenagers were getting was that adults had given up on them and even expected them to be sexually active."

Chad Jackson, 18, of Fairfax, Virginia, joined the campaign at a "True Love Waits Banquet" at his local Baptist churst last October. Good looking and popular, he has made no secret of his pledge. "Some people get on my case and there is a bit of case and there is a stuff behind my back. But mostly they respect it and it even opens the opportunity to talk about it," he says. And he displays a rock-like certainty about his choice. "If you think about it, although I haven't met her yet, I am already showing my wife how much I love her."

Rhianna Ayers, 17, plays in the girls soccer team in her school, where, she admits, sex and boys still dominate locker-room chat. But she feels no discomfort as a devotee of chastity. "The majority of my school do have sex, but in my group of friends it's the cool thing to do the opposite.

The trend has found strong resonance in political discussion. For the Christian Right, which is exerting an ever-increasing influence on the Republican Party, purity is at the heart of the "family values" doctrine. Even President Bill Clinton is taking note. Plans to overhaul the US welfare system, unveiled last month, including a proposal to spend $ 400m (£261m) on teaching abstinence in schools.

"It seems to be an idea whose moment has come", suggests Dr Marion Howard, who 10 years ago pioneered an abstinence project for the mostly black state school system in Atlanta. She was inspired after conducting a sex education survey among teenage girls and discovering that 82 per cent complained that what they wanted to know above all was how to say "No" when pressurised. Called "Postpone Sexual Involvement", her course is now a model for the President's programme.

Dr Howard claims impressive results. According to her own data, children aged 13-14 who take the PSI course at school are four times less likely to engage in sexual activity than those who do not. The differential narrows but remains significant as the children get older. Nonetheless, Dr Howard believes still that the pressure on children to try sex remains overwhelming even among 9 and 10-year-olds. "It has become the societal norm. They think sex is just part of growing up and dating."

On the front line of Dr Howard's programme are the "teen-leaders" who are paid by Atlanta to teach the course in the hope that they will make a greater impression than adults. One is Jade Rutland, 16. "We do become role models for some of these kids and a very important influence," she said. "We teach them about friendship and also why it's important not always to run with the crowd. When you know that you're making your own decisions, it's easier to say 'No'". Jade sees, if not a tide, then certainly a new current of chastity. "I don't think it's a fad, but I do think that more people are deciding to abstain. I think it's a change in society."

Recent statistics from the Sex Information and Education Council of the United States (Siecus) suggest that changing attitudes are indeed leading to new practices. In a 1994 study recently released, the Council found that teen sexual activity is declining — 36 per cent of high school students reported having had sexual intercourse compared to 54 per cent in a comparable 1990 study by the Centres for Disease Control and Prevention.

(By arrangement with The Independent)

Good health can never go out of fashion....

A mutually faithful relationship means more stability, stronger bonds and a lifelong friendship. It also means freedom from many diseases like AIDS and STDs.

.... as long as we live !